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1 Executive Summary

The main facts determining the Spanish political agenda along 2011 have been the economic crisis and the electoral process. The effects of the crisis do not seem to remit in Spain. In the last quarter of 2011, the unemployemt rate has reached a new maximum (22.85%, with 50% for the young aged under 25). The negative perspectives in the Spanish labour market have inverted a huge immigration wave starting around 2000 which causes in 2011 a negative immigration flow. This negative perspectives in the short run add to the long run challenges related to the demographic cycle. With some delay compared to most of the developed countries, Spain is expected to experience a pronounced ageing process as the Spanish baby boomers will start retiring by around 2020.

Those challenges faced by the Spanish policy agenda are now taken up by the new government. This does not seem to have a direct intention to restrain social protection, but the need to cut public deficit and the decrease in revenues due to high unemployment rates will force this kind of measures while the crisis continues. The need to cut expenditures has directly affected pensions, health and long-term care provisions.

First, with respect to pensions, the 2011 reform was one of the last achievements of the former government. It has been an important step towards the sustainability of the system. The movement towards proportionality has been sizeable and, for the first time, an explicit sustainability factor has been introduced. Nevertheless, the changes are going to be implemented progressively during quite a long period, from 2013 to 2027. Moreover, some further adjustments need to be made in order to ensure sustainability. First, full proportionality of the contributory system would clarify the role of redistribution, now somehow mixed up. Second, given the fact that the system has already had its first deficit in 2011, the adjustment factor should be more clearly specified and perhaps activated before 2027. Otherwise, all the burden of the adjustment will be left to future workers.

Second, in the case of health, measures are concentrated mainly on personnel and pharmaceutical costs, which might not affect directly the provision of the service. The objective of reducing the deficit to 4.4% of GDP for 2012 makes further reductions foreseeable. On the one hand, implementing the 33/2011 Act the former government set a reference framework, according to which equity and health are the guiding principles in all policies. The new government has promised to maintain the standard of access and quality of health service, proposing a pact for health care and social services. On the other hand some Autonomous Regions started a legislation phase to reduce budget in their health systems. Improving the productivity performance of human resources and introducing shared services by health care providers (health and long-term care) represent some of the possible measures to cut spending in the long run. Hence, the development of health information system to enhance comparative analysis at a sub-national level represents an important challenge for the evaluation of system performance and its rationalisation. The legislation on public health and prevention, introduced by the 33/2011 Act, might improve population health conditions and avoid growth in health expenditure.

Finally, in the case of the long-term care, a slowdown of the implementation process of the system introduced in 2007 has occured. The public budget dedicated to long-term care was diminished by 5.2% in 2011, reversing the gradual increase since the implementation plan was established. A one year delay of incorporating the group of moderate dependents has been decided, being a way to recognise the financial realities in most of the regional governments. It is worth mentioning that this constraints might be limiting the perspectives of sectors with good employment aspects in the medium term.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The main facts determining Spanish political agenda along 2011 have been the economic crisis and the election process. Snap elections were announced on the 26 September for the 20 November and a change of government occurred - from the socialist party (PSOE) to the popular party (PP). The elections in the biggest Autonomous Region in terms of population – Andalusia - will be held on 25 March 2012. A change of political preferences similar to the one on the national level is expected. The socialist party has been governing in Andalusia since the 80s. This fact is probably influencing the approval of the 2012 public budget which is announced for this March.

The effects of the crisis do not seem to remit in Spain. In the last quarter of 2011 the unemployemt rate has reached a new maximum (22.85%, with 50% for the young aged under 25). The average duration of unemployment in Spain is 14.8 months, while it is only 9.6 months in the OECD countries. Job instability[1] is also extremely high - 25%, while the EU27 average is 14%. The expenditures on unemployment have doubled from 2007 to 2011. The negative perspectives in the Spanish labour market have inverted the huge immigration wave starting around 2000, so that in 2011 a negative immigration flow has been produced. The INE estimates that 507,740 people have left the country (62,611 being Spaniards), while only 457,650 have entered in 2011.

The activity of the former and current governments tried to follow the Council recommendations on the Stability Programme of Spain 2011-2014, but in 2011 it ended up with a public deficit to GDP of 8% instead of the expected 6%. Three of those recommendations constitute the declared priorities of the new government and an additional one - the pension reform - being one of the last significant actions of the former government. The pension reform process was completed (24/2011 Act), with increase of the retirement age and changes towards stronger proportionality between contributions and pensions being the main aspects (see details in Section 2.2).

In the following, a brief reference to the actions taken by the new government in line with its priorities and its impact on social protection is given:

a) Budget strategy at the national and regional level to correct the excessive deficit. This has motivated a change in the Spanish constitution, something that had not happen in Spain since the political transition in 1975. This measure was enacted by the former government and it was agreed upon by the main opposition parties.

In this line, reform measures from both the expenditure and the revenue side have been introduced. On the expenditure side, austerity measures have been continuing, affecting social protection, as explained below. Public employment in particular has been frozen. On the revenue side, one of the first measures introduced by the new government at the end of 2011 was an increase in income tax. Being a progressive tax, this does not in principle worsen redistribution, as it would an increase in VAT.[2]

[1] Job instability is defined as the share of part time workers over total workers.
[2] There have also been an increase on the property taxes.

b) The monitoring of the ongoing restructuring of the financial sector has continued, affecting especially the savings banks.

c) The labour market reform, launched in 2010, is a priority of the new government. In fact it has been the object of one of its first measures. There was a first attempt to obtain joint proposals by stakeholders (unions and employers' organisations), but only a moderate increase in wages of 0.5% was agreed upon. The government has just approved a Royal Decree (3/2012) which continues the process of reducing the costs of employees release. It also includes some measures to promote employment, like allowing deviations from collective bargaining at firm level.

The current government does not seem to have a direct intention to restrain social protection, but the need to cut public deficit and the decrease in revenues due to high unemployment rates are forcing this kind of measures while the crisis continues.

Finally, some pending tasks on the Spanish political agenda, probably due to the need to cope with the current crisis in the short term and with transfers to the old in the medium term while facing the ageing of the population are worth mentioning. The debate on sustainability of the welfare state often ignores the need to balance the intervention between both sides of the dependents' life cycle. This is especially relevant in the Spanish case. The Spanish welfare state is imbalanced on both sides of the dependents' life, contrary to most EU countries. While transfers to the elderly are mostly financed by public transfers and savings, young citizens are mainly financed by private transfers.[3] This, together with the inefficient working time schedules, makes it very difficult to combine work and family and might explain the slow recovery of the fertility rate in Spain. The current crisis should not stop the initial efforts made recently in Spain to improve public benefits for young people.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The Spanish public pension system is organised in two main schemes, both of them unfunded, i.e. financed on a pay-as-you-go (PAYG) basis. The most important one - the contributory system - is mainly a defined-benefit system. It is contributory or *Bismarckian*, i.e. benefits are related to contributions, and it covers retirement, disability, maternity and survivors risks. Parallel to this, in 1990 a non-contributory means-tested system was introduced for those individuals, who are not elegible for the contributory system. This system covers around 5% of total pensioners, mainly women, and it is financed through general public revenues.

The contributory system is mandatory for all employees and also for the self-employed. The majority of workers are covered by the Social Security, which manages more than 93% of the contributory pensions and contributions.[4] In December 2011, the number of Social Security pensions was 8.9 milion (8.7 in 2010), of which 59.7% are retirement pensions, 26.2% widowhood, 10.6% permanent disability, 3.1% orphan and 0.4% other recipients. The number of contributors to the system was 17.2 milions (almost 0,4 million people less than in the previous year). It is worth mentioning that in 2011, for the first time since 1999, the system suffered a small deficit (an estimated 0.06% of GDP).[5]

[3] See Patxot et al., (2011) for an estimation of the National Transfer Accounts for Spain and Patxot et al., (2012) for a discussion on the balance issue.

[4] There are special schemes for some workers: civil servants, justice system and the army.

[5] The 24/1997 Act established the isolating of financing sources and the Social Security stopped financing health services in 1999.

Since the launching of the Social Security system in 1967, different reforms have been implemented, mainly aiming to further foster proportionality between contributions and pensions. Concerning retirement pensions, the most important changes took place in three directions: the minimum contribution period, the initial benefit calculation and the retirement age. First, the minimum contribution period has increased from 10 to 15 years in 1985, remaining unchanged from then on. Second, the formula to calculate initial benefit has been modified several times. In general, initial benefit is calculated as a percentage (depending on the years of contribution) of a "base pension" (obtained as an average of past earnings). Initially, the base pension was obtained with only the last 2 years of contributions paid prior to retirement. Subsequent reforms have increased this period to 8 years in 1985, 15 in 1995 and finally, to 25 in the last reform approved in 2011 (progressively from 2013 to 2027). Regarding the percentage applied to the base pension, it has been the same since 1967 until the 2011 reform, except of the marginal adjustment due to the increase in the minimum contribution period. Initially, the first 15 years of contribution entitle to maximum 50% of the base pension; from then on, each additional complete year entitle to 3% more until the 25th contribution year, and to 2% more for each additional year from the 26th to 35th contribution year. So, the maximum benefit was achieved with 35 or more years of contribution. From 2027 on, the proportionality between the contribution period and benefits will increase for those with more than 15 minimum years of contribution, measuring the intervals in months instead of years. The maximum benefit will be reached with 37 or more years of contribution. Third, the retirement age has been also modified. The most important reform in this sense has been approved in 2011. On the one hand, a general delay of two years in the legal retirement age has been established, from 65 to 67 – also with a progressive application from 2013 to 2027. Nevertheless, retirement with a full base pension at the age of 65 will be possible for individuals with 38.5 or more years of contribution. On the other hand, new requirements for early and delayed retirement have been also approved, in order to rise the effective retirement age. Being still high for EU standards according to OECD data, the effective retirement age in Spain has decreased sharply from 66.8 years for men (72.4 for women) in 1970-75, to 61.8 (63.4 for women) in 2004-2009. Interestingly, a new pathway to early retirement is available from employment from age 63, while before the reform was only possible for the unemployed from age 61 and from workers in old mutualities. Additionally, the share of the pension base received as a pension has been modified to foster delayed retirement. On the one hand, the weight given to contribution years has been adjusted to a maximum of 37 years (instead of 35). On the other hand, the incentive to stay in the labour market beyond statutory retirement age has been increased. The premium to continue working beyond the statutory retirement age has been increased from 2% per year (or 3% with more than 40 contributed years) to a scale of 2% to 4% depending on the number of contribution years (4% only with 37 contributed years). Although it is not yet actuarially fair it is a substantial increase and can contribute to a higher participation rate of older workers on the labour market.

Finally, it is worth mentioning that the 2011 reform introduces an explicit sustainability factor in the pension system. From 2027 on, the main parameters of the system will be revised on a five year basis, taking into account the changes in life expectancy at age 67 along this period. Nevertheless, the exact formula for that revision is not specified.

In spite of its contributory character, the Social Security system also plays an important redistributive role. On the one hand, the relation between contributions and benefits is not linear (except for the existence of a minimum contribution period, individuals with shorter laboral histories are, in general, more favoured). On the other hand, maximum and mimimum thresholds exist for both contributions and pensions.

2.2.2 Debates and political discourse

The debate about public pensions in Spain follows to a great extent the recommendations proposed by the Toledo Agreement (Pacto de Toledo) in 1995. The latter was the result of a negotiation between the government, other political parties and workers as well as corporate firms' representatives. The main output of the negotiation was a document containing a set of recommendations and compromises for a periodical implementation. However, as most experts recall, several parts of the proposal were vague and did not result into a concrete policy change. Reforms enacted since then were indeed timid and have not yet fulfilled the expressed proposals.

The strong effect of the current economic crisis in Spain and international pressure to protect euro credibility has lead to a new reform launched in February 2011. After hard negotiations, the reform was accepted by social agents and finally approved in August 2011. It contains the strongest version of the general proposals outlined in the Toledo agreement. As detailed above, the most noteworthing measures are the general increase of retirement age – from 65 to 67 – and the change in the calculation of the initial benefit, which will be more proportional as having into account 25 years of contributions instead of 15. Moreover, for the first time an explicit sustainability adjustment was introduced from 2027 onwards, although the exact formula was not specified.

After the 2011 reform, there is still some discussion on several issues. First, regarding the indexation of pensions, in 2011 all the pension benefits, except the minimum ones, were frozen, while for 2012 a 1% increase was announced. Second, some actions could be implemented regarding flexible retirement pathways and the adjustment needed to punish early retirement and foster delayed retirement on an actuarially fair basis. In particular completely actuarially fair premiums and punishments could be introduced (see Jiménez-Martín, 2012).[6] Furthermore, given that the flexible retirement pathways is not used, perhaps further incentives to work longer like pension increases could be implemented.

Finally, in January 2012, the new government has announced additional tax privileges for private pension plans for the next months. Private pensions in Spain are quite low compared to other European countries. In 2009, according to OECD, Spain had accumulated 9.4% of GDP in private pension funds, in line with Austria or Portugal, but far from countries like Denmark and Netherlands which have accumulated above 150% of their GDP in private pension funds.

2.2.3 Impact of EU social policies on the national level

The pension reform was finally enacted in August 2011 following the guidelines of the Annual Growth Survey.[7] Trade unions were not only resistant to any reduction in pensions, but also highly reluctant to accept an increase of retirement age, despite the fact that life expectancy has increased dramatically since the normal retirement age was fixed when the system was introduced. But finally, they accepted both elements. The gradual increase of the statutory retirement age from 65 to 67 is a substantial achievement in terms of sustainability. Moreover, partial retirement, which is in fact a way of early retirement, has been constrained. Early

[6] This note proposes a completely flexible retirement age from a minimum age with actuarially fair retirement coefficients. This flexibility might be desirable from the workers' perspective but in the current context one should worry about the extent to which this would ensure sustainability. In particular it is suggested allowing early retirement at the same age from employment (now 63) and unemployment (now 61) to avoid strategic behaviour. This could be possible a measure though it is not clear to what extent it will impede using unemployment as an early exit to retirement without worsening the pension level.

[7] http://ec.europa.eu/europe2020/pdf/ags2012_en.pdf. These recommendations were reinforced by the country specific suggestions in http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:212:0001:0004:EN:PDF.

retirement is also directly reduced by the increase in the minimum retirement age. Nevertheless the possibility of retiring for the unemployed at the age of 61 is maintained with an increase in the required contributed years for eligibility to 33. This being more acceptable in the current business cycle position, there seems to be a concession to the unions in the possibility of voluntary early retirement at 63 and 64. At present, the possibility of voluntary (from employment) early retirement was practically eliminated. Only a transitory situation allowed it to workers affiliated to the old mutual system – those who contributed before January 1967. After negotiating with the trade unions, the government introduced the possibility of retiring from the age of 63. Eligibility requirements include a minimum contribution period of 33 years and pension entitlement not being below the minimum pension.

2.2.4 Impact assessment

Current pension adequacy in Spain seems to be high for EU standards. The theoretical replacement rate (TRR) is the 3rd highest of the EU27, after the Netherlands and Luxembourg. The aggregate replacement ratio is the same as the EU27 average. This contrast is partially explained by looking at the past evolution of the aggregate replacement ratio, which has been improving faster in Spain that in the EU15. This is probably due to the final phase of the maturing process of the pension system on the one hand, and to the delay in the reform of the pension system on the other hand, corresponding to delay of the Spanish baby boom. Another reason might be that the Spanish pension system is not highly redistributive for EU standards. The change in TRR for high and low income workers is not very high –Spains position in income change with respect to the 24 countries with data is the 14th for high income workers and 21st for low income workers.

Looking at the percentage of people at risk of poverty or social exlusion, Spain's index is worse than the EU average. Interestingly, the gap decreased in 2005 and 2006, but started to increase again since 2007, showing a stronger impact of the economic crisis in Spain than in other countries. It should be noted that the general trend of this poverty index in Spain is mainly driven by the population aged under 65, while the elderly show the opposite trend. This is clearly an effect of the continuation of social protection along the crisis. Social protection acts as an insurance for the elderly while working people bear the consequences of the economic crisis. Nevertheless, the 2011 reform might change this picture to some extent as it will cause a general cut in the pension rights in the long-term. Still, the elderly might be more protected against the business cycle, but the cut in the level of pensions will imply a downward trend in their relative income.

Although the application of the 2011 reform is going to be progressive – from 2013 to 2027 –, its effects on adequacy and sustainability are expected to be substantial. Regarding the latter, according to the estimations of the spanish government, expenditure will decrease by 3.5 percentage points of GDP in the long-run (11.5% instead of 15% in 2050), which will pull the amount of pension expenditure below that of Italy, France and even Germany. These results should be taken with caution, as the effects of the economic crisis do not seem to have been taken into account explicitly.[8]

Conde-Ruiz and González (2012) and Banco de España (2011) compare their preliminary estimations of the 2011 reform effects to government results, and also to previous estimations of the impact of similar reforms: delay in retirement age, increase of the number of years to estimate the base pension and change in the weight given to contributed years. The results for similar reforms give similar impacts in terms of expenditure to GDP. In any case, all those

[8] Note that the estimated 15% of pension expenditure to GDP ratio in 2050 comes from the 2009 AWG estimations closed before the crisis hit the Spanish labour market.

studies are based on aggregate accounting models or overlapping generation models with limited degree of heterogeneity and are therefore unsuitable for measuring future pension adequacy. Anyway, the reform will help facing population ageing, improving sustainability, but affecting pension adequacy at the same time. A thorough analysis should be carried out to make sure that the cut in pensions does not worsen adequacy to a great extent. Cohort and micro simulation analysis would be convenient in order to clarify the inter and intra generational effects of the reforms.

2.2.5 Critical assessment of reforms, discussions and research carried out

The 2011 reform has been an important step towards the sustainability of the Spanish pension system. The movement towards proportionality has been sizeable and, for the first time, an explicit sustainability factor has been introduced. Nevertheless, the changes are going to be implemented progressively during quite a long period, from 2013 to 2027. Moreover, some further adjustments need to be made in order to ensure sustainability. First, full proportionality of the contributory system would clarify the role of redistribution, now somehow mixed up. Second, and given the fact that the system has already had deficit in 2011 for the first time, the adjustment factor should be more clearly specified and perhaps activated before 2027. Otherwise all the burden of the adjustment will be left to future workers.

Moreover, other specific actions are possible while trying to face population ageing and ensure sustainability of the system. First of all, it should be pointed out that the Spanish unemployment rate is the highest in Europe (22.85% the last quarter of 2011), and it represents a big handicap in order to keep the necessary ratio between workers and beneficiaries. Spain urgently needs appropriate changes in the labour market in order to stop and reverse the present job destruction trend. In this sense, the labour reform announced by the government for February 2012 can help and should be directed to the youth in the short run in order to avoid that they experience a negative cohort effect. Secondly, some specific groups such as older workers or women can in the medium run represent a good resource to help improve the ratio between contributors and beneficiaries of the system. In this case, changes to gender and age management in the labour market are also necessary. It is true that more contributors now imply more pensioners in the future but, with the convenient adjustments in the system, this should not be a problem. For that, the proportionality between contributions and benefits should be fulfilled, although this might harm adequacy.

The non contributory system can always help people who do not meet the conditions for the contributory system. But the main measures should be directed to incentivate individuals to work and save for their retirement, through the public system and also through occupational and individual plans.

A thorough consideration of both short term and long-term sustainability and adequacy would require a micro simulation exercise with adequate macro scenarios. Unfortunately, this is not yet available, but a combination of the output of the AWG (Ageing Working Group) and the ISG (Indicator Sub-Group) of the SPC (Social Protection Committee) can be a useful approximation.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The Spanish National Health System is the result of an evolution from an insurance system which guarantees free health care only for low-income workers to a Beveridgean National Health System (NHS), ensuring it to all citizens. In 1984 the primary health care system was

reformed, rural hospitals were constructed and the overarching 1986 *Ley General de Salud* founding the Spanish health system was implemented. Since 2001, some Autonomous Regions hold exclusive jurisdiction in determining public health spending, and modify partially the tax structure that supports their income (extended in 2009). In January 2002, the 10 remaining Autonomous Regions assumed full responsibilities from the *Asistencia Sanitaria de la Seguridad Social,* and health financing was totally integrated into the common financing of each Autonomous Regions, through tax baskets. The *Pais Vasco* and *Navarra* constitute an exception to this rule, because they have the right to collect all taxes directly and then give back an agreed quota to the central government as payment for national services. This configures a totally devolved health care system[9], in which Autonomous Regions bear full responsibilities and large management and organisation powers. Consequently, total public expenditure in 2009 was distributed among Autonomous Regions (91.15%), Civil Servant Mutuality (2.92%), Social Security (2.37%), local government (1.82%) and the central administration (1.74%).[10]

The Interterritorial Council (*Consejo Interterritorrial del Sistema de Salud*), chaired by the Ministry of Health Social Services and Equality[11] (MHSSE), is the highest coordination and decision-making institution and is composed of the seventeen Autonomous Regions secretary of health. Decisions are taken by consensus, after being informed by the work of specific expert committees with broad territorial representation. Autonomous Regions do not maintain a hierarchical relationship to general state administration and therefore report the decisions to their respective parliaments. They are responsible for organising and planning the health system and social services, respecting the minimum framework of the NHS common portfolio. The Autonomous Regions Health departments act as the health regulation, assurance and strategic planning authority, being responsible for operational planning, management and coordination of the network provision. Eleven out of seventeen Autonomous Regions' health services have taken the form of autonomous administrative bodies, the other five are public bodies and one is a public regional company. The provider network mainly adopts a vertically integrated organisation with direct management. There is also a variety of experiences in implementing indirect forms of public and private management in service provision. The MHSSE has competencies on drug policy and international health and ensures the same level and quality of services for all NHS users.

Coverage of the population is universal, but it is not a citizens' right[12], meaning that access to the system is based on employment and dependancy on someone who is employed or due to lack of means. There are three formulas determining access to health coverage. The general social insurance regime is the most common formula and still has the same name as it did when the statutory system was a social insurance scheme. The second formula is for civil servants and their dependants who have a special social insurance regime, allowing them to either stay within the NHS or opt out. The third formula available applies to foreign residents in Spain and is regulated by the Organic Law 4/2000. Coverage includes all foreign legal residents, regardless of their nationality or country of birth and of their legal situation, who are entitled to

[9] The Law of quality and cohesion of the NHS of May 2003 adapts the government organs to the new federal arquitecture http://www.boe.es/boe/dias/2003/05/29/pdfs/A20567-20588.pdf.

[10] http://www.msps.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.

[11] The real decree 1823/2011, of December 21 modifies the name of the Minister of Health, Social Policies and Equality into Minister of Health, Social Services and Equality http://www.boe.es/boe/dias/2011/12/22/pdfs/BOE-A-2011-19939.pdf. Moreover the new government of *Partido Popular* changed the structure of the Ministry of Health, Social Services and Equality to streamline its operation and reduce the high charges initiated by the Royal Decree 1887/2011 of 30 December. This initiative is part of the process undertaken by the new executive to rationalise structures of Central Government and reduce the number of senior positions. These measures are expected to save 487,611.12 per year.

[12] In January law 33/2011 (*disposición addcional sexta*) extended coverage to people that had finished unemployment benefits, almost 200,000 people as estimated by MHSSE.

use the health services provided under the National Health Care System in Spain, with the same conditions as Spanish citizens. Irregular immigrants who have signed up in municipal censuses also gain access to health care. The coverage of services is broad and comprehensive, with the exception of dental care and the prescription of eyeglasses and/or contact lenses. Since 1995, there is a positive and a negative list of publicly financed health care services, the positive list being very wide. Primary care and specialised doctors are mostly civil servants or statutory workers. Primary care services are mainly provided in public health centres. They are the gateway to the system, except emergencies, acting as a door-keeper for access to specialised care.

The private sector functions as complementary coverage of health risks in relation to public health activity. This complementary role can include improving the quality of accommodation in hospital admissions or elimination of waiting times for specialised assistance. Production and provision are mixed up. Both the NHS system and private providers can subcontract each others services. The majority of privately covered individuals enjoy double coverage, private and public, such as those belonging to the three existing public mutual providers, currently: General Mutuality of Civil Servants (MUFACE), the Social Institute of the Armed Forces (ISFAS) and General Mutual Judicial (MUGEJU). In these cases, the public sector allows its employees to freely choose between public or private provision, with no additional cost. The choice is limited to beneficiaries. Law 33/2011 introduced the duty to impute the cost of the service delivered in the public health sector to such public mutualities.

There are no co-payments on visits or diagnosis tests; the only existing co-payment is 40% on drugs prescribed outside the hospitals, pensioners being exempted from this co-payment. Those with certain medical conditions and/or disabilities as well as seniors are also exempted from co-payments. The total share of the population partially exempted from co-payment is 24%.[13]

In the last survey on Opinion and Fiscal Attitudes of Spaniards[14] the IEF (*Instituto de Estudios Fiscales*) shows that Health System is the public service that is improving more compared to other services and 53% of respondents justify tax to finance it. Moreover, 34% of respondents say that it has the largest margin of improvement, followed by the education system (20%) and infrastructure (14%). CIS (*Centro de Estudios Sociologicos*) stated in November[15] that 56% of respondents strongly or quite agree to health care delivered by the NHS and about 46% say that health system receives sufficient funds, while 43% answer that NHS is shortly funded.

Reforms

The Spanish government, with the Royal Decree Law 4/2010 and 8/2010, intended to reduce health care expenditure in 2011 by 8.2% compared to the previous year (*Ministerio de Economia y Hacienda*). The measures have focused on the application of a scale for the reduction of NHS base salary and the three basic items of compensation in accordance with the qualifying group. The reduction of the base salary ranges between 0 and 4.5%, to apply from June to December.[16] Likewise, the remuneration that corresponds to the additional day to cover continuing care (guards) was also reduced by 5%. However, the Autonomous Regions have transferred the management of health and the competence to establish additional remuneration to the health institutions. Furthermore, means for training of health personnel will experience a

[13] OECD, 2011. http://dx.doi.org/10.1787/888932315602.
[14] http://www.ief.es/documentos/recursos/publicaciones/documentos_trabajo/2011_09.pdf.
[15] http://www.cis.es/cis/export/sites/default/-Archivos/Marginales/2900_2919/2910/Es2910.pdf.
[16] Further a 5% reduction in all fringe benefits was applied from June to December in all qualifying groups with the exception of group E (the last on the scale of public servants), to which is applied only a 1% reduction. A reduction was applied to the bonus in December and June and a 5% reduction in other components that make up the bonus, for all qualifying groups with the exception of group E.

cut back of 5% which implies an annual salary lowering from EUR 396.26 for a training nurse and up to EUR 644.30 for a five-year training resident on average. The government will also cut between 0.56% and 7% of civil service salaries. For health sector and social services workers, the work hour effective cost increased by 0.004% in 2010 compared to 2009; the salary effective cost per hour increased by 0.003%, whereas general salaries decreased by 0.0002%.[17] Moreover, in December 2011, the new government approved a wage freeze for civil servants and an extensive reduction of staff - only 10 out 100 health working places will be reoccupied in the coming years. The working time has been extended from 35 up to 37.5 hours per week.

On the other hand, the Spanish Health authorities have attempted to reduce growth in drug expenditures in line with other European authorities. Those measures include the reference pricing system, reduction of wholesale distributors' and retailers' mark-ups and compulsory reductions of ex-factory prices. In this respect, the Royal Decree 9/2011[18] sets a series of austerity measures in the pharmaceutical services which aim to alleviate the financial difficulties in the Autonomous Regions health services.[19] The Spanish Agency for Medicines and Health Products (AEMPS) will work on the adequacy of the contents of drugs packages to the actual duration of treatment, according to the clinical practice.

Moreover, the government, in coordination with the Regional Autonomous governments, shall within six months establish a unique format and common health card valid for the entire NHS. Similarly, before January 1 2013, the health authorities have adopted the necessary measures to ensure interoperability and data sharing across the NHS by digital medical records and electronic prescriptions.[20] A socio-sanitary strategy[21] will be elaborated within six months, aiming to improve the user's services quality. It sets a biennial evaluation mechanism that allows monitoring and assessing results.

On January 23, 2012, the government approved the Royal Decree 200/201[22], amending the structure of the MHSSE. One of the changes affects the management of the Health Institute Carlos III (ISCIII) that depended to the former Ministy of Science and Innovation. The ISCIII will have a dual functional affiliation, with the Ministry of Economy and Competitiveness and the MHSSE. All activities in health and health care planning are devolved to this institute. The institute will work in coordination with the MHSSE in health and health planning, while the activities that may have an application to NHS will be coordinated by the Ministry of Economy and Competitiveness.

Important measures in public health and prevention were introduced. The *Ley General de Salud Publica*[23] *(*33/2011) has set a reference framework, according to which equity and health are the guiding principle in all policies. The legal procedure was contentious and ended with the cessation of the Director of Public Health, the project inspirator and the coordinator. Moreover, the *Ley de Seguridad Alimentaria y Nutrición española*[24] draws measures to combat the trend of increasing rates of childhood obesity. It promotes nutrition education, the benefits

[17] Indice de Coste Laboral Armonizado, (ICLA), INE.
[18] See http://www.boe.es/boe/dias/2011/08/20/pdfs/BOE-A-2011-14021.pdf.
[19] Pharmaceutical providers denouced a NHS hospital debt of EUR 6,300 million, being the average delay of payment 525 days, but four Autonomous Regions exceed 800 days.
[20] The unification of digital medical records and electronic prescriptions culminates a process initiated in 2005 with the *Sanidad en Linea* project.
[21] http://www.imserso.es/InterPresent2/groups/imserso/documents/binario/asociosanitaria2011.pdf.
[22] http://www.boe.es/boe/dias/2012/01/24/pdfs/BOE-A-2012-1034.pdf.
[23] http://www.boe.es/boe/dias/2011/10/05/pdfs/BOE-A-2011-15623.pdf.
[24] The law 17/2011 (July 5th, 2011) *Ley de Seguridad Alimentaria y Nutrición española*[24] http://www.boe.es/boe/dias/2011/07/06/pdfs/BOE-A-2011-11604.pdf.

of physical activity and regulates the sale of food and drinks within schools. Furthermore, law 42/2010 modifies the previous anti-smoking law of 2006, tightening anti-smoking restrictions and outlawing smoking in any enclosed building open to the public, apart from some exceptions. Bartenders who do not respect new law may face fines ranging from EUR 601 to EUR 100,000.

A new ethical medical code[25] was approved in July 2011. Some of the main modifications are: the duty for doctors to inform their patients about their rights and/-or to solve any medical problems that could arise; the attempt to cure the patient "when possible", when it is not "the obligation to implement appropriate measures to ensure their well-being, although it shortens life[26]"; the obligation for physicians to prescribe the cheaper drug, given the same effects, something that the OMC (*Organización Medica Colegial*) has contested.[27]

The Royal Decree 1039/2011[28] defines the maximum access and waiting time, expressed in calendar days, for surgical intervention, outpatient care or diagnostic or therapeutic procedures within the NHS. This time is counted from the user entry date in the registration queue. The decree defines the maximum guarantee of access and the commitment made by the Autonomous Community Health Service to treat the patient with appropriate quality conditions within the maximum time access granted.

Data on consolidated expenditures for 2009[29] show, at sub-national level, an increasing expenditure in health care with an average increase of 8% between 2008 and 2009. A budget constraint was implemented in La Rioja and Castillla y León, whereas Baleares, Catalonia, Extremadura, Madrid, Murcia and Pais Basco were more generous with an average increase above 10%. Catalonia is one of the regions were health budget was reduced more, namely by 15.6% compared to 2010.

2.3.2 Debates and political discourse

The financial adjustment phase including the approval of a constitutional rule, which will enhance system sustainability, is in process. This commitment is indirectly pushing Autonomous Regions to reduce their debt, affecting the health care budget.

Last June[30], P PSOE (*Partido Socialista Obrero Español*), together with UGT and CCOO, the leading labours unions agreed on a guiding principle for reforming NHS, defining criteria to increase revenue for the health system and the search for common formulas with the Autonomous Regions to facilitate payment of the debt owed to health care providers. On the other hand, any savings that might be produced are intended to finance public health services. Moreover, the MHSSE is expected to lead the implementation of the measures taken to ensure the enforcement of acquired rights and the current level of system access.

During the last electoral campaign, the debate on NHS reform was marginally covered. PSOE[31] stressed the NHS historical progress. Health coordination strategies between social and health care sectors were proposed, stressing the need for an integrated systems and the role of NHS to

[25] https://www.cgcom.es/sites/default/files/codigo_deontologia_medica.pdf.
[26] A bill "*Ley de cuidados paliativos y de muerte digna*" on this issue was studied by the Socialist government.
[27] http://www.elpais.com/articulo/sociedad/nuevo/codigo/etico/enfrenta/medicos/objecion/elpepisoc/20110730elpepisoc_2/Tes.
[28] http://www.boe.es/boe/dias/2011/08/29/pdfs/BOE-A-2011-14190.pdf.
[29] http://www.msps.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
[30] http://www.msps.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=2172.
[31] See http://s01.s3c.es/imag3/pdf/elecciones/Programa_PSOE_2011.pdf.

reduce inequalities. On the other hand, *Partido Popular,* the new ruling party, stressed basically NHS cohesion and universality[32], without any significant proposals.

The debate on reforming NHS is confusing. Finding solutions for sustainable financing of the NHS, offsetting the evolution of public spending in a more appropriate development of public revenue, seems to be the most important debate. Open questions are to be answered prior to financing effective treatments, which public health could not sustain. In some Autonomous Regions, namely in Catalonia, there is an open debate on the introduction of co-payments. A forum in May[33] was devoted to its introduction, given the financial budget constraint. Beside the revenue collected, it seems it could act as a tool for an effective priorisation of the service catalog. Moreover, an internal reorganisation of health care services within the territory,adoption of cost effective criteria in treatment and combating health inequalities are key points of the debate among health professionals.

2.3.3 Impact of EU social policies on the national level

EU social policies seem to have little or no effect on the national debate on health care reform. The consideration of health care policies within the National Reform Programme 2011 can at best be characterised as marginal. The drop in revenue since 2008 and increasing pressure for financial stability pact has led to a constitutional reform introduced in spring 2011. It fixes a maximum deficit for the State and Autonomous Regions (Constitutional Reform art. 135/2), which will affect the health budget cut. The Spanish Primer Minister announced that the public deficit objective for 2012 will be 5.8% of GDP more than one point above the 4.4% commitment with European Union. Autonomous Regions will have to limit to 1.5% its deficit in 2012, according to the Council of Fiscal and Financial Policy (Consejo de Politica Fiscal y Financiera). Moreover Spain began a regulatory phase in order to tackle obesity, with special attention to childhood obesity through education and health systems, responding to the 2007 European Commission White Paper and to the gradual deterioration of the quality of food, poor physical activity of the European population as a whole and the associated risks of obesity.

2.3.4 Impact assessment

Overall, the performance of the NHS is positive. Total health expenditure per capita in Spain is USD 3,067 in 2009, below the OECD average of USD 3,233.[34] Between 2000 and 2009 the annual growth rate of per capita health expenditure was 4%, similar to OECD average. Expenditure per capita is distributed among public (73.6%) and private (26.4%), being those rates similar as OECD.[35] In 2009, the number of hospital beds[36] per 1,000 inhabitants was 3.2 (2.5 hospital beds are for curative, 0.4 for psychiatric and 0.3 for long-term care[37]) below the OECD average (4.9) and decreased from 2000 (3.7). The average length of stay in hospital for all causes has decreased from 7.6 in 2001 to 6.9 days in 2009, which is below the OECD average.[38]

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[32] See The electoral Program of *Partido Popular* http://www.pp.es/actualidad-noticia/programa-electoral-pp_5741.html.

[33] http://aes.es/foro/.

[34] Data collected by the MHSSE show that health expenditure by inhabitants is 2011 euros in 2009 with a 2% increase respect to 2008, being 74% financed by public expenditure, Indicadores Clave Del Sistema Nacional De Salud 2011.

[35] OECD, 2011, ibidem.

[36] OECD, 2011, ibidem.

[37] OECD, 2011, ibidem.

[38] OECD, 2011, ibidem.

The expenditure on health personnel wage in 2009 is 45.13% of the total expenditure, being 42.07% in 2005. Rate of primary care doctors per 1,000 inhabitants is 0.75, being 0.71 in 2005, while rate of specialised personnel care is 1.81 being 1.60 in 2005. In 2010 practising doctors were 174,100 in Spain, 3.78 per 1,000 inhabitants, being the figures similarly to those for 2005. In 2011 Autonomous Regions health care staff amounts to 501,186 representing 18.6% of the overall number of public servants[39], and shows an important interterritorial variation.

The current economic scenario seems to suggest further health expenditure cuts to come. The personnel and pharmaceuticals costs were the first to be reduced in view of their impact on the system accounts and the urgent need to reduce current spending. Autonomous Regions are likely to adopt a more diversified expenditure cut in health care; for this reason efficiency and rationality criteria are necessary in order to maintain the same levels of performance and lower costs.

The moderation of growth in drug spending has appeared in both the average cost per prescription, which has decreased by 10.23% compared to 2010, and the number of prescriptions billed, which increased by 1.62%, below the increase (2.56%) registered in 2009. In the last month of 2011, pharmaceutical expenditure amounted to EUR 888.4 million, representing a decrease of 9.74% compared to December 2010, with an interannual reduction of -8.78%. This trend will be reinforced by the royal decree 9/2011, which obliges pharmacies to dispense the lowest price drug without any discretionary delay. Last year spending through official NHS drug prescription amounted to EUR 11,136 million. In 2011, the Autonomous Regions *Galicia, Aragon, La Rioja and Castilla La Mancha* experienced a greater reduction in pharmaceutical bill, while *Melilla, Ceuta* and the *Islas Baleares* increased their spending significantly. In the last decade, drug expenditures decreased from 20.9% of health total amount expenditure to 18.8% at the end of 2009.[40] The consolidated data[41] by the MHSSE, which covers the period 2002-2009, reveals this recent trend. While the price of many drugs fell, the number of prescriptions per person from 1999 to 2009 increased, being the crucial factor in the increasing government spending.

In the field of public health, important reforms were introduced. Equity and health in all policies is the guiding principle of this law, representing a positive innovation in approaching health challenges of the society and a contribution to social and economic development.

A recent study[42] claims that the demographic effect is not the main driver of health expenditure, shifting on the social determinants of health. According to it, a cost-effective and equitable health policy design, which tackles social determinants of health and prevents illness, would reduce the growth rate of health care expenditure. Additionally, a recent study[43] shows that poor mental health is potentially attributable to high employment precariousness, affecting nearly 6.5 million workers, with almost 900,000 of them exposed to high precariousness.

According to an ongoing research[44], there are significant inequalities in health condition due to socioeconomic position; 68% to 74% of these inequalities are due to non-alterable characteristics. Social exclusion is a more important determining factor than income, being something that exceeds health care scope.

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39 http://www.seap.minhap.gob.es/dms/es/servicios/empleo_publico/boletin/boletin/Bol_estad_pers-juli11-INTERNET.

40 See OECD.

41 Source: Gasto público en el periodo 2002-2009. Ministerio de Sanidad, Servicios Sociales e Igualdad.

42 http://www.ief.es/documentos/recursos/publicaciones/papeles_trabajo/2011_03.pdf.

43 http://www.ncbi.nlm.nih.gov/pubmed/22053526.

44 www.ief.es/contadorDocumentos.aspx?URLDocumento=/documentos/recursos/publicaciones/papeles_trabajo/2011_12.pdf .

Projection of health expenditure[45] shows that it will grow in real terms, reaching between 6.4% and 8.8% of GDP by 2060. It implies that public health expenditure will grow at an average annual rate of 1.78% to 2.40%. The expected evolution of the volume and structure of the Spanish population (all the remaining factors constant) will place the percentage of public expenditure on health over the GDP at 7.88% in 2060.

Spain is experiencing waiting list problems in Madrid[46] with an 8.17% increase in waiting time in 2011 with respect to 2010. In Catalonia personnel adjustments, the reduction of hospital beds, chirurgic rooms and other care services have caused waiting lists increased by 24.3% between January and June 2011. In this respect, the Ministry of Health approved a decree limiting waiting time for some chirurgical treatment such as hip and knee replacements as well as cardiac and cataract surgeries. Longer waiting lists are also extended in private health provision as shown by OCU[47] (*La Organización de Consumidores y Usuarios*).

2.3.5 Critical assessment of reforms, discussions and research carried out

The first phase of constraint measures in health expenditure concentrated mainly on personnel and pharmaceutical costs, which might not affect directly the provision of health services. The objective of reducing the deficit to 4.4% of GDP for 2012 makes further reductions foreseeable. Uniform linear reduction may not enhance the long-awaited efficiency.

On the one hand, the new government has promised to maintain the standard of access and quality of health service proposing a pact for health care and social services. On the other hand, some Autonomous Regions started a legislation phase to reduce the budget in their health system.

Improving productivity performance of human resources and the introduction of shared service by health care providers (health and long-term care) represent some of the possible measures to cut spending in the long run. Hence, the development of health information system to enhance comparative analysis at a sub-national level represents an important challenge for the evaluation of system performance and its rationalisation. The implemented policy measures of public health and prevention might be beneficial in order to improve population health conditions and avoid growth in health expenditure, but it is still too soon to evaluate their effects.

Overall, the system seems to function well and health expenditure is moderately low compared to OECD countries. NHS results are extremely positive, but it carries on serious problems such as social inequalities between individuals and households with different income levels and territorial inequalities in accessing decent health care. From this point of view, it is not clear how financial crisis would impact NHS and whether it will deepen health and health care inequalities among Autonomous Regions. Moreover, integrated social care and health care for chronic diseases is still too weak (see LTC).

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

From 1 January 2007 a new law regulating the services offered to dependents became effective in Spain. The so-termed Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia (The Law of Promotion of the Autonomy and Care for People in a

[45] http://www.ief.es/documentos/recursos/publicaciones/papeles_trabajo/2011_03.pdf.
[46] http://www.elpais.com/articulo/espana/Crece/lista/espera/operarse/elpepuesp/20111209elpepunac_6/Tes.
[47] http://www.ocu.org/.

Dependent Situation) establishes the System for Autonomy and Care for Dependency (SAAD) and stipulates the right to access a universal benefit under equal conditions to all the elderly and people with disabilities needing help to execute any of the basic activities of a daily life (BADL).

The public funding of the services and benefits detailed within the law were established, half to be provided by the central administration and half by the Autonomous Region administration, where service suppliers are public establishments (regional or local) in collaboration with the private sector. The Territorial Council of the SAAD was created in order to ensure the application of this law and its coordination between the different levels of authorities. This organ is supervising the collaboration between the General and Regional Public Administrations involved and it also defines the catalogue of services and benefits, the conditions and amount of financial benefits, the co-payments of beneficiaries, and determines the criteria and the dependency scale for eligible beneficiaries. Moreover, there are four other consultative organ, i.e. the SAAD Advisory Committee, which guarantees the communication between employees' and employers' organisations engaged in giving advises and making proposals on matters that are of particular interest to operations of the SAAD. The other three ensure the participation of organisations representing people in a situation of dependency and their families.

The Law stipulates two types of benefits: services and cash benefits. Services are carried out through a public network of social services, controlled by the Autonomous Regions' government, and through public centres or subsidised private centres controlled by the national government. These services include the Telecare service, the home help service, personal care and day and night residential care service. Among the benefits, cash benefits related to services are also available, i.e. a monetary benefit for home care and monetary provision for personal assistance. The first one is granted only when it is not possible to access a public service. Exceptionally, the provision for care in the family environment is recognised, if beneficiaries are being cared for by their families in their own homes. Finally, the personal assistance aims to empower people with higher dependency to hire professional assistance for some hours, thus enabling the beneficiary to access education, work, or other basic activities of daily life.

The main improvement for the long-term care system caused by this law has been a clear shift from a social assistance system to a more universal system. However, five years after the implementation of the law, the responsibility of care continues to rely heavily on families and informal care (Arriba & Moreno, 2009; SAAD, 2011). Despite the existence of service benefits within the law and the clear intention of this policy to increase the supply of caregivers, the Spanish system is characterised by the provision of cash benefits targeted to relatives or informal caregivers, which perpetuates the care system within the family that already existed. By the end of 2010, family caregivers represented 45% of the total benefits (SAAD, 2011), although this possibility was considered by the law as an exception. Though the residential care managers seem to be disappointed by this trend, this is not necessarily negative as long as the citizens choose this option having other available options. Undoubtedly, this implies an increase in public expenditure in the short run. But this is, in a way, anticipating the expected change of actual informal care into formal care in the future as a result of the increase of female participation.

The law was stated to be implemented gradually from 2007 to 2015, when it is expected to be provided for all dependents, prioritising the inclusion of the most dependent persons. It was expected that the moderate dependents would be covered by the law from 2011 on. However, with the the new government in office, this extension has been delayed until 2013.

The budget assigned in order to provide benefits and services of the law has been increasing since 2007. At first, it was stipulated that the State General Administration would contribute with almost EUR 13,000 million for the whole period (2007-2015), starting with EUR 400 million in 2007, whereas in 2010 it was of EUR 1,581 million, contributing in total until the end of 2010 EUR 5,390 million. The crisis has restrained this continuous increment, and in 2011 the amount set to finance the long-term care decreased by 5.2%, being only EUR 1,498 million. On the other hand, the financial contribution to support the fund for the promotion and development of infrastructure and services of the SAAD (EUR 17 million) was maintained in 2011. This fund aims to provide financial support to companies which carry out dependency services, encouraging collaboration between public and private sectors (SAAD, 2011).

The law also considers two mechanisms of private funding to complement the public benefits: the reverse mortgage and a private insurance scheme of dependency. The reverse mortgage offers the possibility to elderly houseowners to access a credit, based on the value of their housing. This financing product has not taken off with much intensity due to a legislation still too vague. In the case of an insurance scheme of dependency, it acts as an insurance policy which in case the dependency stage arrives, offers a benefit, used either totally or partially for dealing with those prejudicial consequences for the beneficiary of this stage. This insurance scheme will benefit from the same tax incentives as other insurance schemes.

Finally, another important aspect of the law is related to the quality of the service and labour market regulation of caregivers. The law gives priority to the provision of services in relation to financial benefits with the intent to promote and stimulate the supply of formal labour market caregivers. The law also sets out the financial support to informal caregivers under the condition that these workers contribute to Social Security as self-employers. This kind of measure diminishes informality and increases control over caregivers. Moreover, the SAAD also promotes training courses for caregivers organised by government institutions like IMSERSO (Instituto de Mayores y Servicios Sociales). These courses have the objective of promoting the necessary training of non-professional caregivers and informing them about the contents of the new dependency law. They try to offer basic knowledge to improve social and health conditions of dependents, offer information about products and techniques that increase the autonomy of the person with dependency, provide emotional support to caregivers and give information about social and health services that guarantee assistance to dependents.

Recent reforms

2011 has been a critical year for social protection provision of long-term care services. There have been several changes in the application of the recent law that need to be emphasised. Some of these changes are a consequence of the economic crisis afflicting the country, and will produce restrictions in the law application, but others have been the result of different assessments and reviews, and have the aim to improve its implementation.

In 2011, the public budget dedicated to long-term care has diminished by 5.2%, reversing the gradual increase of each year since the implementation plan was established. In the same direction, a Royal Decree 8/2010 has stipulated on 20 May the abolition of retroactivity in the delivery of cash benefits to beneficiaries who have been evaluated and considered as beneficiaries, but still have not received the provision, to a maximum of the waiting time of six months.

With the new government, a new Royal Decree 20/2011 of 30 December 2011 confirmed a delay of one year to incorporate the group of moderate dependents. However, Bizcaia and Navarra, the only two Autonomous Regions of northern Spain, where this incorporation already

had started, have declared that they will continue with the calendar of application of the law.[48] This kind of measure may only have the objective to legitimate what has already been done since 2010 by the majority of regional governments of Spain as most Autonomous Regions have decreased the number of new incorporations to the system (IMSERSO-CSIC, 2011).

Among the improvements made, a Royal Decree 6/2010 of 9 April 2010 provided the reduction of VAT on care services to dependents provided by private entities with publicly subsidised vacancies. This modification is expected to give an impulse to this kind of business and increase the supply of services aiming to meet the increasing number of dependents.

Likewise, another enhancement is related to a change in the scale of assessment of dependence by the Royal Decree 174/2011 of 11 February 2011. This modification aims to adjust and improve the reliability of the measurement instruments to achieve a uniform assessment of dependent people in different Autonomous Regions.

Initially, the commitment of the central government and the regional administrations to reduce waiting time for receiving any benefits by persons recognised as candidates to 6 months (from the current 9 to 15 months) has been seen as an improvement (Barriga, 2010). However throughout 2011, nearly all Autonomous Regions have instead increased their waiting time to evaluate candidates and to deliver benefits to dependents already evaluated.

Concerning the financing of the law, there have been several questions that had an impact on its accomplishment. First of all, as a consequence of the austerity measures imposed by the national government on Autonomous Regions pursuing the control of their budgets, there has been a delay of payments to caregivers (public and private) in several regions. This had prejudicial consequences on service delivering to beneficiaries, causing strikes and general discontent among caregivers which were unexpectedly forced to cut off expenditures.[49]

Furthermore, there has been a persistent tension between national and regional governments, concerning the compliance of the commitment of 50% co-founding by the national government. This has caused regional governments to demand a certification of commitment from the national government.[50]

2.4.2 Debates and political discourse

Long-term care has proven to be one of the most vulnerable parts of the social protection provision in front of the austerity programmes imposed by the national government on Autonomous Regions. The new moratorium of the law which delays the coverage of moderate dependents for one year, just follows what the SAAD statistics revealed to be a clear tendency in the majority of Autonomous Regions (IMSERSO-CSIC, 2011). In December 2011 four Autonomous Regions showed negative increases compared to the precedent month and only two had increases over 2%. These indicators mean that some regions are losing beneficiaries.

According to the National Association of Directors and Managers of Social Services, the government is missing a great opportunity to invest in an area that is increasing exceptionally and generates employment. The real concern of this group is that the law never brought the growth expected into the sector, even before the actual economic crisis. Another main concern of care service managers is related to the instability of public transfers payments and the delay of the previewed schedule. This situation is affecting negatively a sector that is already

[48] http://ccaa.elpais.com/ccaa/2012/01/19/paisvasco/1326988361_187127.html.
[49] http://politica.elpais.com/politica/2011/09/02/actualidad/1314984114_704274.html.
http://politica.elpais.com/politica/2011/09/26/actualidad/1317064567_273424.html.
http://politica.elpais.com/politica/2011/10/10/actualidad/1318274839_911420.html.
[50] http://politica.elpais.com/politica/2011/05/14/congreso/1305391817_198786.html.

depending on government prorogation of payments. As pointed out by the Manager´s Federation to assist Dependency (FED), new budget constrains will put in risk thousands of jobs.[51]

In terms of the financial sustainability of the long-term care public system, the new government has showed a deep concern. Willing to reduce public expenditures in that matter, one of the Autonomous Regions - Castilla-La Mancha - is serving as an example to others, as exposed by the national government.[52] Among the changes introduced by this Autonomous Region, candidates to receive a benefit will start paying a fee in order to be evaluated, and the co-payment of some services that were previously free, like day and night care centers and homecare service, will be introduced. Likewise, they propose that the transportation to these centers would be responsibility of the user´s family, unless for exceptional cases where no relative is available.

Moreover, the government is intending to unify the criteria among the different Autonomous Regions[53] and this is becoming an extremely controversial issue. The first problem arises concerning the data. The Dependency Act establishes an official information system, the SISAAD, but not all Autonomous Regions have incorporated it with the same fidelity, causing many differences in their assessment. The lack of a unified information system causes inefficiency in the system. For example, in some Autonomous Regions there has been an accumulation of people considered as beneficiaries, who were already dead, a situation that could be easily enhanced if the information system was integrated with the register. However, there are other issues where the central government needs to unify criteria. Evaluating the dependency level and determining the co-payments for care services are the main examples. A coordination of regional policies would help to take advantages of the most efficient mechanisms of each region.[54]

2.4.3 Impact of EU social policies on the national level

The National Strategic Report on Social Protection of 2008-2010, which was elaborated inside the frame of the OMC, following the European Commission strategies on Social Protection, stresses the priority to deal with the impact of ageing on social exclusion and ensuring the continuation in the implementation of the new Dependency Law. However, the recommendations of the OMC related to budget restrictions have affected the long-term care system in an opposite way, causing a general standstill of the application of the law, both *de jure* and *de facto*. Although assessing the impact on the targets presented by EU2020 is difficult, it would be important to carry out interesting to conduct a descriptive analysis of people covered by the law in order to understand how changes in the long-term care system can affect the well-being of the elderly and vice versa.

The statistics from January 2012 (IMSERSO-CSIC, 2012) show a clear relationship between dependency and ageing, as the majority of people receiving benefits are over 65 years old (78.2%) and 51.7% are over 80 years old. Among all dependents beneficiaries, 65.5% are women and 57.4% of them are also over 80 years old, showing a well-known correlation between ageing and women. However, this data refers only to 1,612,729 people who were beneficiaries or candidates of the public long-term care system. The real amount of dependents in Spain in 2008, according to Abellán et al. (2011) is, in fact, 2,141,404 people aged over 65

[51] http://sociedad.elpais.com/sociedad/2012/01/02/actualidad/1325538079_202039.html.
[52] http://sociedad.elpais.com/sociedad/2012/01/16/actualidad/1326748598_811636.html.
[53] http://www.elmundo.es/elmundo/2012/01/08/castillayleon/1326045762.html.
[54] http://sociedad.elpais.com/sociedad/2012/02/01/actualidad/1328125095_559335.html.

living at home, plus 258,237 living in retirement homes. This number is naturally increasing, as in 1999 there were only 1,621,909 dependants aged over 65 living at home.

EU2020 gives special attention to the commitment on reducing poverty rates. Regarding this matter, the long-term care has an indirect impact, as people with lower income in Spain have four times higher probability of suffering an incapacity before the age of 65 than those with higher income (Pereda et al., 2012). A survey on incapacity from 2008 show that only 1.7% of households with more than EUR 5,000/month had a dependent person between 0-65 years old, but this share reaches 11.3% for households with less than EUR 500/month. It is important to point out that starting with the age of 65 these differences become more balanced. This tendency could mean that the lack of health starts affecting the majority of people aged over 65, but also, that the social protection system, and in part, the long-term care system, helps reducing inequalities. However, the majority of one-person households with a dependent have less than EUR 1,000/month. A tendency that worsens with age (Abellán et al., 2011), revealing the importance of a long-term care system to protect dependents from poverty and social exclusion.

2.4.4 Impact assessment

As mentioned throughout the previous section, there has been a clear and direct impact of the crisis and new policies of austerity on the actual running of the care system for dependents in Spain. The new situation of economic restraints, combined with the recognition of the slowdown in the development and implementation of the LTC system impedes the entrance and evaluation of new dependents in several regions, and causes a delay in payments to caregivers.

The statistics presented by the IMSERSO-CSIC corroborates this tendency. Since the implementation of the law in 2007, 1,612,729 applications had been processed and 1,503,758 assessed (figures as of January 2012). Among the latter, 1,057,946 people were eligible for a service or a benefit (among high dependents), and 752,005 were already receiving their benefit, while the remaining 28.9% are still waiting to receive their benefits. The waiting list has increased from being 25.7% in January 2011 (231,055 people).

Besides the statistics provided by IMSERSO-CSIC which are published every month with the stock of applications, assessments, beneficiaries, types of benefits and number of caregivers, by sex and Autonomous Region, the SAAD also published several evaluations of the application of the law, including information about financing and new affiliations to Social Security related with long-term care services.

Moreover, another institution is in charge of offering indicators to evaluate the system. The National Association of Directors and Managers of Social Services conducts an evaluation of performance of Autonomous Regions regarding the management of the application of the law in relation to the number beneficiaries, applications and assessments, the size of the waiting list and the equilibrium between services and benefits offered. Finally, the Association also evaluates the regional laws pertinent to social services and the good practices implemented. From this evaluation, it can be said that Castilla y León and País Vasco are among the best considered regions and Canarias, Comunidad Valenciana, Asturias, Baleares and Madrid are the worst.

In relation to budgetary issues, in 2007, the amount of LTC public expenditures represented 0.5% of GDP. The new law previewed an increase of public coverage of dependents from 32% of public beneficiaries in 2007 to 68% in 2015, with the consequent increase of the budget, which after 2010 was not possible due to the crisis. The allocation of resources from the government has been every year above the amount forecasted in the budget. In 2009, the public co-payment initially planned in the law has been exceeded. By 2010, the funding from the

national government exceeded the one considered in the budgetary provisions of the law by 60%. In 2010, it was the first time that the assignment of the government to regional administrations decreased by 4.8%. Moreover, in 2011, as mentioned above, a decrease of the budget devoted to LTC by 5.2% was expected.

Despite this short-term tendency of decrease in LTC expenditures caused by the actual restriction policy, including the Dependency Law implementation, the projections from the European Commission expect that this percentage will rise to 1.4% of GDP in 2060 (European Commission, 2009). National projections, like the one presented by Rivero & Moral (2011), also expect that the total cost of dependency in Spain will increase 2.79 times from 2007 to 2045. Nevertheless, none of these projections considers that there will be a shortage of informal care in the future, which actually represents almost half of the total aid transferred to beneficiaries of the law. A recent study by Durán (2011) quantifies the non-paid work (devoted in a great measure to care of children and elderly) as being 53% of GDP.

During the development of the Law there have also been some improvements in the LTC public system. 260,406 new social security affiliations as social services workers have been registered since 2007 - a number that contrasts with the job losses experienced by the Spanish economy during this period. This increase affects the shortage of experienced workers in the sector, which is gradually being rectified (Fujisawa and Colombo, 2009). Moreover, the cash assistance directed to family caregivers has especially benefited women, who represented 83% of informal carers in 2010. In their majority, these women are aged between 45 and 65 years and unemployed. Therefore, the cash benefit has increased the visibility of this kind of informal service, improving the economic and social well-being of this group.

These statistics coincide with the fact that the figure of the home caregiver to high dependents, which usually is a family member and that should have been an exceptional situation, has become, on the contrary, the most common situation. By the end of 2010, family caregivers represented 45% of total benefits to high dependents. Moreover, 30% of the total benefits to all dependents were professional services i.e. teleassistance, home care service, day/night care service, to dependents living at home (SAAD, 2011). The principal causes of the high prevalence of family care givers are a historic tradition of performing this kind of services inside the family, an important percentage of rural dependents (around 30% of dependents) and a high percentage of house owners among the elderly who are co-residing with other family members (Pereda et al., 2012).

Moreover, during 2011, there has been an assessment of the information delivered by the Autonomous Regions to the Central State. The datasets of dependents have been frequently cleaned and the system has found several errors, like a not negligible amount of dependents treated as receiving benefits, or beneficiaries registered several times in the dataset.[55] This incident recalls the importance of improving the information system of the SAAD, in order to improve the control of expenditures and the coordination of services among Autonomous Regions. The increase of transparency in this area is crucial to improve access, efficiency and quality of the system.

Finally, to assess the quality of the system, an ongoing research is being conducted by the CSIC (Superior Council on Scientific Research) and the CIS (Center of Sociologic Research) about the satisfaction of the Dependency Law. This research includes a survey for beneficiaries, caregivers and beneficiaries from retirement houses. The results have not yet been published, but they will be extremely valuable to assess quality of care delivered to beneficiaries of the law.

[55] http://politica.elpais.com/politica/2011/06/07/actualidad/1307468052_056954.html.

2.4.5 Critical assessment of reforms, discussions and research carried out

The year 2011 has been deeply marked by a context of austerity measures that have forced the public system of long-term care to a general standstill. This has revealed the vulnerability of this component inside the social protection panorama. Though it is a sector that could bring economic growth and higher employment, as shown by the number of new affiliations of social security related with the implementation of the law.

The fact is that the SAAD needs to preview a serious forecast of the funding needed in the coming years, in order to confront the continuation of the system once the ageing process increases the number of dependents. This impairment was born at the same time as the law, when a sustainable plan to finance the system was not considered, and the budget only preview its application until 2015. The paralysation of the actual system could not be a better solution, as it puts into a vulnerable position both beneficiaries and caregivers, and, moreover, it does not implies a high saving to public costs (the coverage of moderate dependents would represent only a 0.6% of total SAAD benefits). The new government could be missing an opportunity to finally put into practice a more adequate long-term system which could be a driving force for economy at the same time ensuring the wellbeing of people in a state of dependency.

Besides the budget constraints, the SAAD needs to improve other aspects of its management and implementation, like the coordination between the Central and the Autonomous Regions Administrations, the homogenisation of quality criteria and the functioning of the information system. The government has showed a clear interest in solving these issues and focusing on these improvements could increase efficiency of the system.

Finally, another possible action could be a carefully analysis of good practices executed among the Autonomous Regions. In the case of Spain, an outstanding example, as presented by the Observatorio de la Dependencia of 2010, is the performance of Castilla y León that has integrate and coordinate the action of public professionals, local entities and non-governmental associations. From the beginning, the government of this region promoted the consensus among all sectors involved in the long-term care system. Moreover, it presents a perfect accomplishment in its model of monitoring, in its good practices and its innovations in the sector. This good performance implies also a high rate of candidates already receiving a benefit (73.2% compared to a national average of 70.4% from SAAD, 2012), which means that the waiting list is among the shortest compared to other Autonomous Regions.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

One of the critical aspects of the 2011 reform of the pension system is the increase of the statutory retirement age by two years. This is a clear consequence of the increasing life expectancy as well as the increasing health life expectancy. The reform also considers a strong intention in reducing early retirements. Likewise, the reform includes increasing the minimum number of contributed years needed to receive the higher amount of pension benefit. These measures will consequently increase the percentage of older workers in the labour market and will change the actual outlook where the retirement age was on average 63.66 years. Though average retirement age is quite high for European standards, the participation rate for older workers is quite low, especially for women.

In the case of Spain, working part time and receiving pensions at the same time was prohibited. This prevents retirees with good health from continuing their employment, unless they want to give up the pension benefit to which they contributed their whole life. Partial retirement and

flexible retirement were introduced in 2002, but these pathways have been used more to anticipate retirement than to delay it.

Confronted with this situation, the new government declared prior to the elections the intention to promote a change, which would allow retirees to continue working in exchange for reducing their pension benefit. The need to reduce early retirement has also been thematised after the elections.

2.5.2 Participation in society

Spain is not seen as a country with a high presence of voluntary work. Compared with other European countries, Spain is placed at the end of the ranking, with only 18% of the population being engaged in voluntary work. Historically, the voluntary work was executed by women over 40 years old, although this feature is rapidly changing during the last years.

The government presented a Strategic Plan of Voluntary Work for the period 2010-2014, which includes actions to promote voluntary work of the elderly as an instrument of active ageing. However, the Plan is so recent that there are no results or actions that can be assessed yet (MSPSI, 2010).

2.5.3 Healthy and autonomous living

The government has been greatly conscious about the importance of activity among the elderly, promoting health and autonomous living. For this reason, the IMSERSO (Instituto de Mayores y Servicios Sociales) has several programmes in order to encourage active ageing among retirees. Among them are the holidays programme, the thermal baths programme, the tele-assistance programme, the “close to you” programme and a website that promotes good practices among rural elderly (enclaverural).

Each of these programmes is devoted to different aspects of leisure of the elderly or to promoting their health. Both the holidays and the thermal baths programmes are designed to offer holiday packages or bath terms stays at lower prices than those offered at the market. The tele-assistance programme ensures an immediate intervention when there is a personal, social or health crisis of an elderly person, 24 hours a day. In a similar way, the programme “close to you” offers comfort to those elderly feeling alone, as this situation often cuases illness, depression and incapacity conditions. Finally, the website enclaverural is an open and free website that gathers rural interventions related to ageing, incapacity or social services in order to make them more visible and serve as examples to other communities.

Moreover, the public sector also offers other types of services which promote the autonomy and activity of elderly people, like leisure houses or social centers, where the elderly can meet and develope social interaction, take different courses and participate in physical activities or cultural entertainment.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R1; R3] CONDE-RUIZ, J. Ignacio, GONZÁLEZ, Clara I., Reforma de pensiones 2011 en España: una primera valoración. FEDEA. Colección Estudios Económicos, 01-2012.

"*The 2011 pension reform in Spain: A preliminary evaluation*"

The aim of this paper is to evaluate the impact of the pensions reform approved in 2011. We use an accounting model with heterogeneous agents and overlapping generations in order to project revenues and expenditures of the pension system for the next four decades. Specifically, we analyse the impact of changes in the replacement rate, in the period of calculation and the delay of the retirement age.

Moreover we obtain the results under two alternative migration scenarios: i) a combination of the latest released by the INE where immigration net flow is reduced to 70.000 persons by year and ii) a revised scenario with a more generous and realistic hypothesis about immigrants net flow. The results show that these three changes could imply a saving of around 3% of GDP in 2051. However, we couldn't include in the evaluation the "sustainability factor" (that transform the Spanish system in a defined contribution scheme) that will start in 2027 due to the lack of details in the text of the Reform. Finally, we analyse the changes in average pensions by sex, skill and nationality.

[R1; R3] BANCO DE ESPAÑA, Informe Anual 2010. BdE, Madrid.

"*Annual report by the Spanish Central Bank, 2010*"

This is the annual report published by the Central Bank in Spain. In particular, from page 64 to 67 an overview of Spanish pension system is presented. Moreover, the effects of recent 2011 reform are evaluated considering the results obtained by different studies carried out by different authors. In all cases the reform seems to have a significant effect on cutting public expenditure to GDP in the long run.

[R3; R4] BOLDRIN, Michel, GARCÍA GÓMEZ, Pilar (2010). Social security incentives, exit from the workforce and entry of the young. In: GRUBER, Jon, WISE, David (eds). Social Security programmes around the world: the relationship to youth employment. Chicago University Press for the NBER, p. 261-294.

This book groups together an intercountry comparative analysis of the effect of social security incentives on the exit rate of old workers, with special attention to the interaction between this magnitude and the entry rate of the young.

[R2;R5] FERRUZ AGUDO, Luis, ALDA GARCÍA, Mercedes, MUÑOZ SÁNCHEZ, Fernando. Planes y fondos de pensiones privados en España: características, ventajas y evolución de sus principales magnitudes. Boletín económico de ICE, Información Comercial Española, ISSN 0214-8307, Nº 2973, 2009.

"*Private pension schemes and funds in Spain: Characteristics, advantages and evolution of their principal magnitudes*"

In the present context of economic crisis, social protection turns out to be a very important aspect for all citizens. One of the key features and the more distressing is the public system of pensions. Factors like the increase of life expectancy, an earlier age retirement or unemployment question the viability of the public pension system in the medium term, as we know nowadays, a fact already pointed out by different bodies. In relation to this concern of a majority of citizens, an alternative that shows up as a solution, at least in some part, is participation in private pension funds. This study carries out an exhaustive description of the Spanish market of private pension funds and analyses the principal magnitudes that characterise it, and describes its evolution since its beginning until the present.

[R3; R5] JIMÉNEZ MARTÍN, Sergi. Propuestas para la Reforma de la Jubilación Anticipada en España, Apuntes FEDEA, Bienestar 08-2012.

"*Proposals for a reform of early retirement in Spain*"

This is a short note discussing possible measures towards a flexible retirement system fostering delayed retirement.

[R1] PATXOT, Concepció, RENTERÍA, Elisenda, SÁNCHEZ-ROMERO, Miguel, SOUTO, Guadalupe. How intergenerational transfers finance lifecycle deficit in Spain, in Lee and Mason eds., Population Ageing and the Generational Economy: A Global Perspective. Edward Elgar Publishing Ltd. 2011.

In this book chapter the first estimates for Spanish National Transfers Accounts (NTA) for Spain are presented. The excess of total consumption on labour income – the life cycle deficit – and the way it is financed through age reallocations via market, public, or private transfers, are obtained. The book contains similar analysis for 22 countries, together with methodological and comparative chapters.

[R1] PATXOT, Concepció, RENTERÍA, Elisenda, SÁNCHEZ-ROMERO, Miguel, SOUTO, Guadalupe. Measuring the balance of government intervention on forward and backward family transfers using NTA estimates: The modified Lee Arrows, International Tax and Public Finance, 2012 Forthcoming.

In this paper a way to measure the degree of government intervention on forward –from parents to children– and backward –from adult children to elderly parents– intergenerational family transfers (IFT) is proposed. A discussion is carried out about the possibility of using Generational Accounts (GA) and National Transfer Accounts (NTA) methodologies to generate indicators that could measure government intervention on both sides of IFT. As a result, we propose a modification of arrow diagrams used by Lee (1994b). An illustration of the results in the Spanish case indicates that the degree of government intervention on backward IFT is above that on forward IFT. This could be one of the main reasons to explain the Spanish low fertility rate.

[H] Health

[H1; H3] BERNAL DELGADO, E et al. Documento de Debate. La sanidad pública ante la crisis. Recomendaciones para una actuación pública sensata y responsable. Asociación de Economía de la Salud. Madrid, 2011. Retrieved from:

http://www.aes.es/Publicaciones/DOCUMENTO_DEBATE_SNS_AES.pdf

This document of debate was produced by the Health Economics Association. It provides a list on possible guidelines of NHS reforms.

[H1] BLANCO MORENO, A et al. Projecting health care expenditure in Spain under different scenarios: methodology and results, 3/2011. Retrieved from: http://www.ief.es/documentos/recursos/publicaciones/papeles_trabajo/2011_03.pdf

This paper estimates the foreseen evolution of Spanish health care expenditure until 2060 under different scenarios, assuming changes in demographic and health status variables, as well as in income elasticity of the demand for health care services. The effect of proximity to death is also considered in the estimations.

[H1] Gasto público en el periodo 2002-2009. Ministerio de Sanidad, Servicios Sociales e Igualdad. Retrieved from:
http://www.msps.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf

"*Public Expenditure between 2002-2009*"

This document is produced by the Ministry of Health, Social Services and Equality and it shows the evolution of Public Expenditure between 2002-2009.

[H1] Opiniones y actitudes fiscales de los españoles en 2010, Instituto de Estudios Fiscales. Madrid. Retrieved from:
http://www.ief.es/documentos/recursos/publicaciones/documentos_trabajo/2011_09.pdf

"*Opinions and fiscal actitudes of Spaniards in 2010. Institute for Fiscal Studies*"

This survey of fiscal opinion and attitudes of Spanish population is provided yearly by the IEF.

[H1] Opinión Pública y Política Fiscal, 2011, Centro de Investigaciones Sociológicas. Madrid Retrieved from:
http://www.cis.es/cis/export/sites/default/Archivos/Marginales/2900_2919/2910/Es2910.pdf

"*Public Opinion and Fiscal Attitudes*"

This survey of fiscal attitudes of Spanish population is provided yearly by the CIS.

[H3] URBANOS, R Impacto de las políticas públicas en las desigualdades en salud: una propuesta de medición y monitorización. Retrieved from: www.ief.es/contadorDocumentos.aspx?URLDocumento=/documentos/recursos/publicaciones/papeles_trabajo/2011_12.pdf

"*Impact of public policy on inequalities in health: a proposal for measuring and monitoring*"

This study calculates the associated socio-economic inequality in the distribution of health problems of the Spanish population and identifies its main determinants. It concludes that socioeconomic inequalities are very significant and are preventable. Exclusion is a factor explaining the most important inequalities of income, indicating that measures to reduce inequalities should focus primarily on deprived population. Social inequalities in health are explained by factors that go beyond the scope of health care.

[H3] VIVES, A et al. (2011) Employment precariousness in Spain: prevalence, social distribution, and population-attributable risk percent of poor mental health. International

Journal of Health Service, 41(4):625-46. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/22053526

"*Employment precariousness in Spain: prevalence, social distribution, and population-attributable risk percent of poor mental health*"

This study aims to determine the prevalence of precarious employment in the waged and salaried workforce in Spain. It describe its distribution across social groups defined by occupational class, gender, age, and immigrant status, and estimate the proportion of cases of poor mental health potentially attributable to employment precariousness.

[H4; H5] LÓPEZ CASASNOVAS, G El futuro del sistema sanitario: ¿Anclar el gasto o mejorar su financiación? Gestión Clínica y Sanitaria, 13 (1). Valencia 2011. Retrieved from: www.fundsis.org/docs/Revista-de-Gestion-Clinica-y-Sanitaria-47.pdf

"*Anchor spending or improve their funding?*"

This is an analysis of the evolution NHS financing, focusing on the pros and cons of co-payment introduction.

[H4; H5] ORTÚN, V, La refundación de la Atención Primaria, Springer Health care. Madrid 2011. Retrieved from: http://www.upf.edu/catedragrunenthalsemg/_pdf/La_refundacixn_de_la_Atencixn_Primaria.pdf

"*Reforming of Primary Care*"

This book collects some articles about primary care reforming. It collects a serious of paper about primary care of some of the Spanish leading scholars in this field.

[L] Long-term care

[L] ABELLÁN GARCÍA, A., ESPARZA CATALÁ, C., PÉREZ DÍAZ J. (2011) Evolución y estructura de la población en situación de dependencia. Cuadernos de Relaciones Laborales Vol. 29, núm. 1, p. 43-67.

"*Evolution and structure of dependent population*"

Dependency is defined for the purpose of this paper as having difficulties for activities of daily living and the need of receiving personal care. There are two millions of dependent people in Spain (2008). Dependency rate increase with age and are higher among women and people of lower educational level. There is a relationship between the sequence order and the prevalence of disabilities that lead to dependency. Outdoor mobility problems are usually the first and most commonly cited problems, followed by difficulties in performing housework and subsequently by difficulties in basic activities of personal care. Family support is the most common answer to dependency. Women play a key role: as mothers of young dependents, mothers, wives or daughter of adult males with disabilities, or daughters of parents with functional disabilities.

[L] ARRIBA GONZALEZ DE DURANA, Ana; MORENO FUENTES, Francisco Javier. El tratamiento de la dependencia en los regímenes de bienestar europeos contemporáneos. Colección Estudios, Serie Dependencia, n. 12007, IMSERSO, 2009.

"*The treatment of dependency among contemporary European welfare systems*"

The study, commissioned by the IMSERSO, has the aim to progress in the comprehension of the development of social protection policies in Spain, enshrined by the debates on Welfare Systems in Europe and their recent reforms. It gathers several papers, most of them with a

comparative background, that analyse different paths followed by European countries to respond to the care and attention necessities of their citizens.

[L] BARRIGA MARTÍN, Luis Alberto. Evolución gráfica de la gestión del SAAD por CCAA. Asociación Estatal de Directores/as y gerentes de Servicios Sociales, 2010.

"*Graphic evolution of the SAAD management by Autonomous Regions*"

The objective of the study is to give an overarching perspective for each Autonomous Region in Spain of the implementation and managing of the SAAD. The analysis emphasises the use of graphics and visual resources to exhibit the evolution of the indicators.

[L] DURÁN, María Ángeles (2011). El trabajo no remunerado. Nota de prensa. Fundación BBVA. Retireved on 02/02/2012 at:
http://www.fbbva.es/TLFU/tlfu/esp/noticias/fichanoticia/index.jsp?codigo=835

This study carries out an innovative analysis about relevant concepts like work, needs, quality of life, freedom and coaction. It shows the constant interaction between paid and not-paid work, between households and government and it arises the internationalisation of this processes through migrations. Using United Nations sources, the author estimates the demand for care in the short and long-term in all great regions around the worlds and those relevant countries on population and economy.

[L] GUTIERREZ, Maria Fernanda, JIMENEZ-MARTÍN, Sergi, VEGAS SANCHEZ, Raquel, VILAPLANA, Cristina. The Spanish long-term care system. FEDEA, April 2010.

The study gives an overarching description of the long-term care system in Spain, focusing especially in the application of the new Law of Dependency. It describes not only its organisation, management, coordination and types of services, but also the regulation of the labour market related to social services for dependents.

[L] JIMÉNEZ-MARTÍN, Sergi, VILAPLANA PRIETO, Cristina. Perspectivas de la atención a la dependencia. Temas a debate sobre Economía de la Salud, FEDEA, n. 2009-02, 2009.

"*Perspectives of the Attention to Dependency*"

This article aims to add a new dimension to the debate generated by the implementation of the new Law of Dependency. It explores not only the demand of care but also the future offer of formal and informal caring.

[L] LIBRO AMARILLO. Presentación del proyecto de presupuestos generales del estado, 2011. Retrieved from: www.meh.es

"*Yellow Book. Presentation of General State Budget project, 2011*"

The Libro Amarillo presents the General Budget from the State for 2011. It details all the expenditure adjustments presented to reduce the public deficit, which is one of the main objectives of the present budget. All the adjustments follow what is called the Stability Programme, but the accounts also show how part of the budget is also assigned to maintain social cohesion and contribute to improve modernisation of the productive structure.

[L] MINISTERIO DE SANIDAD, POLÍTICA SOCIAL E IGUALDAD. Estrategia Estatal del Voluntariado 2010-2014. Informes, estudiso e investigación 2011.

"*National strategy of volunteer work 2010-2014*"

It describes the National Strategy Plan on volunteer work approved by the ministry of health and social affairs. The document gathers the several consultancies that the government has established jointly with third sector companies and organisations. The document has the

objective to orient a new strategy to promote volunteer work that rising from the third sector but that would be also a reflection of the actual social situation.

[L] OBSERVATORIO DE LA DEPENDENCIA, Desarrollo e implantación territorial de la ley de promoción de la autonomía personal y atención a las personas en situación de dependencia. IV Dictamen del Observatorio, Asociación Estatal de Directoras y Gerentes en Servicios Sociales, January 2010. Retrieved from: http://www.directoressociales.com/

"*Development and territorial implementation of the Law on Dependency. IV Observatory Report*"

This new report analyses the initial years of the implementation of the law. It mentions as its cornerstone points: the important advance in the implementation of the SAAD; how the best option to develop the SAAD seems to be its integration in the System of Social Services and the reinforcement of those at the local level; how funding problems are not of much volume, the problem consisting rather in the criteria for the distribution of central funding among regions and the control mechanisms on real expenditure; the evolution in the consolidation of proceedings; the still important number of people waiting to make effective their assigned benefits; the predominance of economic transfers over services, contrary to the principles informed in the law; and the still scarce development of home help. The report includes again an updated ranking of all Spanish regions and three annexes. The first one focusses on the funding and costs of the law. The second is an analysis of the agreement of the Territorial Council regarding the evaluation of people in dependency, and the third is a graphic analysis of the evolution of the SAAD management per region between June 2008 and December 2009.

[L] PEREDA, Carlos, PRADA, Miguel Ángel de, ACTIS, Walter (Colectivo Ioé). Discapacidades y Inclusión Social. Colección Estudios Sociales, n. 33. Obra Social "La Caixa", Edicions 62, S.A, 2012.

The present study describes the situation of people with an incapacity and the ways they find to be inserted in adult life. It uses the last survey on discapacity available in Spain, from 2008, to analyse the characteristics of incapacities, the factor that are related to them and ways of treatment. They also explore pathways of socialisation and social inclusion. The principal dimensions studied are educational level, professional status, activity status, and family life, friend's networks and associations. There is also a section examining the role of caregivers to people with an incapacity. Finally, there is an overview on how the evolution of family institutions, changes in gender roles, economic conjuncture and changes in public policies like the introduction of the new law of dependency, under the perspective of people with incapacities or a situation of dependency.

[L] SAAD, Datos estadísticos del Sistema para la Autonomía y Atención a la Dependencia, Instituto de Mayores y Servicios Sociales, retrieved from:

http://www.imsersodependencia.csic.es/estadisticas/saad/index.html

"*Statistical data of the System of Attention of Dependency (SAAD)*"

Monthly information and evolution of the situation of the system including: demands; profile of claimers; evaluations and dictums; degrees and levels of dependency; recognised benefits/services; agreement for non-professional carers; minimum level of protection guaranteed by the Central Government.

[L] SAAD. Portal de la dependencia. Estructura. Retrieved in 2011 from:

http://www.dependencia.imserso.es/dependencia_01/saad/estructura/index.htm

"*The official website of the System for Autonomy and Care of Dependency*"

The System for Autonomy and Care of Dependency is sustained inside a constitutional framework based on the collaboration, cooperation and participation of the different public administrations implied. This official website of the System for Autonomy and Care of Dependency offers information about the structure, services, documents, data and practical issues related with the application of the new Law.

[L] SOSVILLA RIVERO, SIMÓN. "Un Análisis Estratégico del Sistema para la Autonomía y Atención a la Dependencia," Economic Reports 23-08, FEDEA, 2008. Retrieved from: http://www.fedea.es/pub/est_economicos/2008/23-08.pdf

"*A strategic analysis of the system of promotion of autonomy and protection of dependency*"

This article analyses the situation of dependency in Spain with data from 2005, reviews the main characteristics of the SAAD, examines attention to dependency in Europe and estimates the effects that the SAAD can have on the economy and on employment. Finally, it does a SWOT analysis of the SAAD and identifies four main strategies of action. They are related to the incorporation of disadvantaged groups into the labour market; the use of a territorial solidarity fund to alleviate differences among regions; the establishment of professional profiles suiting SAAD's needs; and a higher collaboration and coordination among public and private (for-profit and non-profit) providers.

[L] SOSVILLA RIVERO, Simón, MORAL ARCE, Ignacio. Estimación de los beneficiarios de prestaciones de dependencia en España y del gasto asociado a su atención para 2007-2045. Gaceta Sanitaria, 26: 12, 2011.

The aim of the article is to provide estimates of the number of dependent individuals per grade and level for the period 2007-2045 and the cost associated with the care of these individuals for the System for Promoting the Autonomy and Care of Dependent Persons [Sistema para la Autonomía y Atención a la Dependencia (SAAD)]. They applied a two-stage estimation procedure to project the number of dependent individuals. In the first stage, we calculated the probability of a person being dependent and entitled to benefits by using a logit model. In the second stage, using an ordered logit model, we calculated the probability of distinct grades and levels of dependency in dependent persons entitled to benefits. Subsequently, we calculated expenditure projections based on average cost per point scale by grade and level of dependency. Results suggest a higher incidence of situations of dependency in female beneficiaries than in male beneficiaries, with higher growth rates for almost all categories of grade and level between 2007 and 2045. We estimated that in 2045 there will be 1,592,798 beneficiaries of the SAAD (596,332 men and 996,466 women). Moreover, between 2007 and 2045 the cost of care for dependent people will be multiplied by 2.64 for male beneficiaries and by 2.89 for female beneficiaries, amounting to 41,926 million euros in 2045.

4 List of Important Institutions

Agencia Estatal de Evaluación de las Políticas Públicas y la Calidad de los Servicios (AEVAL)- National Agency for the Evaluation of Public Policies and Quality of Services

Contact person: Ana Mª Ruíz Martínez (Director Evaluation Department)
Address: C/ Príncipe de Vergara, 108, 4ª Planta 28002 Madrid
Phone: (+34) 91273 28 66
Email: presidencia.agencia@aeval.es
Webpage: http://www.aeval.es/

This Agency performs an institutional role combining the goals of improving the quality of public services, rationalising the use of public funds, and enhancing the public accountability of government bodies. The goal of the Agency is to: improve public services and our understanding of the effects on society of public policies and programmes; promote more rational public spending and optimal use of resources; support the productivity and competitiveness of the Spanish economy by removing red tape; and enhance accountability to citizens and reinforce democratic quality by promoting transparency and participation.

Asociación de Economía de la Salud (AES) - Health Economy Association

Contact person: Enrique Bernal Delgado (president)
Address: C/ Bonaire, 7 08301 Mataró (BARCELONA)
Phone: (+34) 93 755 23 82
Webpage: http://www.aes.es/
Email: secretaria@aes.es

The Asociación de Economía de la Salud (AES) is a non-profit private association. It was constituted formally in 1985, although it was already developing activities before then, in particular the annual conference from 1980. It was created to group all professionals devoted to and/or interested in health economics. The number of members has grown steadily during the last decades, so that it reached 680 in April 2004 (36% are economists, 39% are doctors and the rest come from other fields of specialisation). The most common areas of research include: hospital management, health administration, public health, economic evaluation and pharmacy. Publication of AES include: 'Boletín Economía y Salud', technical reports and positioning documents. AES also manages ECONSALUD within RedIris.

Asociación Estatal de Directores y Gerentes de Servicios Sociales de España – Spanish Association of Social Services Directors and Managers

Email: directoressociales@hotmail.com
Webpage: http://www.directoressociales.com/

This Association was created in 1994 and includes at present almost two hundred professionals holding management positions in social services. The Association has a special presence in Andalusia, Madrid, Aragón, Castilla y León, Castilla La Mancha, Comunidad Valenciana, La Rioja and the Basque Country. Its main aims are to promote scientific meeting, research and publications aiming to improve social services organisation and management. Since May 2008 it has published four reports related to the development and territorial implementation of the Law on Dependency and the framework and an observatory that monitors the law.

Banco de España - Bank of Spain

Contact person: Juan Jimeno (Head of the Research Department)
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Email: juan.jimeno@bde.es
Webpage: http://www.bde.es/

The Banco de España is the national central bank of Spain. It was established in Madrid in 1783. It is a public independent advisory body responsible for defining and implementing the Eurosystem's monetary policy, conducting currency exchange operations, promoting the sound working of payment systems in the Euro area, issuing legal tender banknotes, holding and management of currency and precious metal reserves not transferred to the European Central Bank, providing treasury services, etc. It is also a financial agent for government debt etc. The Bank of Spain is also an autonomous adviser to the Government. It prepares and publishes reports and studies, as well as statistics relating to its functions and assisting the European Central Bank in the compilation of statistical information. These reports and studies are aimed at the regular monitoring of the Spanish, Euro-zone and world economies, the evaluation of relevant economic policies, financial regulation and supervision. The regular publications of the Bank of Spain include: an Economic Bulletin, the Annual Report, the Financial Stability Report, the Report on Banking Supervision in Spain, as well as other specific reports, books and volumes.

Centro de Investigaciones Sociológicas- Center for Sociological Research

Contact person: Félix Requena Santos
Address: Calle Montalbàn, 8, (28014) – Madrid
Phone: 0034 (0) 91 580 76 00
Webpage: http://www.cis.es

The Centro de Investigaciones Sociológicas *(CIS) is an autonomous body under the Ministry of the Presidency. Its main functions are to collect data needed for research in diverse areas, from the evolution of publicopinion to applied research in a specific topic. CIS is responsible for conducting studies to provide accurate diagnosis to guide the work of public authorities responsible for the different administrations. These studies are carried out through collaboration agreements and sometimes involve the collaboration of other government agencies or research. CIS edits the REIS, one of the leading journals in the field of sociology in Spain.*

Círculo de empresarios - Entrepreneurs Network

Contact person: Claudio Boada Pallerés (President)
Address: Paseo de la Castellana, 15, 6º (28046) – Madrid
Phone: 0034 (0) 915 78 14 72
Webpage: http://www.circulodeempresarios.org

The Círculo de Empresarios is a private institution which represents the interests of business and big firms in Spain. It was created in 1977 and is aimed at the study, spreading and promotion of free business activity as an essential component of economic and social progress. The Círculo de Empresarios constitutes a space for open debate and opinion on social and economic issues. It publishes monographs and reports.

Comisiones Obreras (CC.OO.)-Secretaría Confederal de Política Social - CC.OO. Social Policy Secretariat

Contact person: Rosana Costa Navarro (Head of Social Policy Secretariat)
Address: C/ Fernández de la Hoz, 12, 28010 Madrid
Phone: 0034 (0) 91 702 80 91
Webpage: http://www.ccoo.es/csccoo/menu.do

The Spanish trade union CC.OO has been since its origins one of the main active social partners in the inclusion of dependency issues in the political agenda, elaboration and analysis of the implementation of the Law on Dependency.

Comité Español de Representantes de Personas con Discapacidad (CERMI) - Spanish Committee of Disabled People

Contact person:	Luis Cayo-Pérez Bueno (president)
Address:	CERMI c/ Recoletos 1º Bajo 28001 Madrid
Phone:	0034 (0) 91 360 16 78
Email:	cermi@cermi.es
Webpage:	http://www.cermi.es/

Confederation of a wide range of associations that defend the interests of people with disabilities and related illnesses.

Confederación Española de Organizaciones Empresariales (CEOE) - Spanish Confederation of Business Organisations

Contact person:	Pilar Iglesias (Director of Security and Health and Safety Area)
Address:	Diego de León, 50 (28006) – Madrid
Phone:	0034 (0) 91 566 34 00
Email:	piglesias@ceoe.es
Webpage:	http://www.ceoe.es/

The Confederación Española de Organizaciones Empresariales (CEOE) is the major representation of the Spanish business community. It is the legitimated interlocutor of the Government and the trade unions in social dialogue, social concentration and collective bargaining processes at national level. The CEOE also carries ongoing analyses of the Spanish economy and the social and labour situation, in order to propose solutions for increasing the competitiveness of Spanish firms. It publishes books and reports on these issues.

Confederación Española de Organizaciones de Mayores (CEOMA) – Spanish Confederation of Elderly People Associations

Contact person:	José Luis Méler y de Ugarte (president)
Address:	C/ Pío Baroja 10. Edificio Cantabria. 28009 Madrid
Phone:	0034 (0) 91 573 52 62
Email:	ceoma@ceoma.org

CEOMA is a non-governmental, cross-sector federation dealing with the coordination, promotion and defence of elderly people interests.

Consejo Económico y social de España (CES) - Economic and Social Council of Spain

Contact person:	Marcos Peña (President)
Address:	c/ Huertas, 73 (28014) – Madrid
Phone:	0034 (0) 91 429 00 18
Email:	webmaster@ces.es
Webpage:	http://www.ces.es/

The CES is a central government advisory body on socio-economic and employment issues. It has public legal status, full capacity and organisational and functional autonomy. It has a tripartite composition, including social partners' representatives, civil servants and other independent experts. The CES draws up opinions on broad social and economic issues, on a mandatory or optional basis, for consultation processes, as well as preparing surveys and reports on its own initiative on the fields covered by its remit. It also draws up an annual report

on the socio-economic and employment situation in Spain. CES' regular publications include an Annual Socioeconomic and Labour Report as well as other reports in specific topics and the journal 'Cauces'.

Consejo General de Colegios Oficiales de Médicos de España - General Council of Medical Associations of Spain

Address: Plaza de las Cortes, 11 (28014) – Madrid
Phone: 0034 (0) 91 431 77 80
Email: webmaster@cgcom.es
Webpage: http://www.cgcom.org/

The Consejo General de Colegios Oficiales de Médicos de España is a private organisation representing the interests of the 52 Medical Associations existing in Spain. It constitutes a very active pressure group for health & care policy design in Spain. It also supports research and training activities carried out by its members.

Consejo General de Trabajo Social - General Council of Social Work

Contact person: Ana Isabel Lima Fernández (director)
Address: Avda. Reina Victoria 37- 2ºc, 28003 Madrid
Phone: 0034 (0) 91-541-57-76 / 77
Webpage: http://www.rediris.es/list/info/econsalud.html

This is a public service created in 1988, interconnecting computer services of universities and research centres. It is a distribution list of scientific information related to health economics and moderated by a webmaster. One needs to subscribe but subscription is for free.

Escuela Julián Besteiro (Unión General de Trabajadores, UGT) - Julián Besteiro School, (Unión General de Trabajadores, UGT)

Address: c/ Azcona, 53 (28028) – Madrid
Phone: 0034 (0) 91 589 78 01
Email: informacion@ejb.ugt.org
Webpage: http://www.ugt.es/ejb

The Escuela Julián Besteiro is a private institution belonging to the Spanish trade union Unión General de Trabajadores (UGT). It aims at the promotion of analysis on social and economic issues, focusing on employment and labour market trends. However, it is more active in training and debate than in scientific research.

Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP) – Federation of Associations for the defence of Public Health Care

Address: c/ Arroyo de la Media Legua, 29, local 49 (28030) – Madrid
Phone: 0034 (0) 91 333 90 87
Email: fadspu@gmail.com
Webpage: http://www.fadsp.org/

The Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP) is a private organisation representing the interests of professionals and citizens in the Spanish public health care system. It constitutes a very active pressure group. It also publishes books and reports, as well as a regular journal ('Revista Salud 2000').

Federación Empresarial de Asistencia a la Dependencia- Business Federation of Dependecy Assistance

The Federación Empresarial de Asistencia a la Dependencia was founded in order to unify a large national employerorganisation to the entire care BusinessSector Unit, encompassing all operators active in this area: residential, night and day centers, home help services and telecare services.

Contact person:	Juan Manuel Eguiagaray Ucelay (Director)
Address:	Paseo de la Castellana, 134 1 (28046) – Madrid
Phone:	0034 (0) 91 466 6161
Email:	secretaria@federacionfed.org
Webpage:	http://www.federacionfed.org

Fundación Alternativas - Alternativas Foundation

Contact person:	Juan Manuel Eguiagaray Ucelay (Director)
Address:	c/ Zurbano, 29 – 3º izq (28010) – Madrid
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Email:	jmanegui@alternativas.org
Webpage:	http://www.falternativas.org/

The Fundación Alternativas is a private non-profit research institution. It was established in 1997 as a think tank and a channel for political, social, economic and cultural reflection. The areas of expertise of the Fundación Alternativas range from issues of a socioeconomic nature (such as the model of growth for the Spanish economy, systems of family support, or challenges facing the welfare state) to those related to the quality of democracy and security of the public. These areas are developed in different sections: the Alternativas Laboratory is aimed at promoting the formulation of rigorous analysis and proposals. The Observatory of Spanish Foreign Office (OPEX) is dedicated to the monitoring of Spanish foreign policy in the European and global context. Estudios de Progreso is a programme aimed at young researchers. The Alterativas Laboratory is the general research service of the Fundación Alternativas. It publishes a highly relevant Working Papers series available online.

Fundación Banco Bilbao Vizcaya Argentaria (BBVA) - BBVA Foundation

Contact person:	Francisco González Rodríguez (President) / Carmen Iglesias Cano (Advisory Committee)
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Phone:	0034 (0) 91 374 54 00
Email:	informacion@fbbva.es
Webpage:	http://www.fbbva.es/

The Fundación BBVA is a private research and training institution linked to the BBVA Group. The Foundation engages in the promotion of research and transmission of scientific knowledge to society at large, focusing on the analysis of emerging issues in five strategic areas: environment, biomedicine and health, economy and society, basic sciences and technology and arts and humanities. The BBVA Foundation designs, develops and finances research projects in these areas, organises award schemes for researchers and professionals and communicates and disseminates such knowledge through publications, debates and lectures.

Fundación Banco Santander - Banco Santander Foundation

Contact person:	Antonio Escámez Torres (President) / Javier Aguado Sobrino (Director Manager)
Address:	c/ Serrano, 92 (28006) – Madrid
Phone:	0034 (0) 91 781 51 58
Email:	fundacionbs@gruposantander.com

Webpage: http://www.fundacionbancosantander.com/

The Fundación Banco Santander is a private institution with a cultural and scientific mission from which it develops an activity of cultural funding in several areas, including socioeconomic issues. Among other publications and reports on financial, social and economy trends, the Banco Santander Foundation publishes the journal 'Moneda y Crédito'.

Fundación de estudios de Economía Aplicada (FEDEA) - Applied Economics Studies Foundation

Contact person: Pablo Vázquez (Director) / Domingo Arranz (Administrador)
Address: c/ Jorge Juan, 46 (28001) – Madrid
Phone: 0034 (0) 91 435 90 20
Email: infpub@fedea.es
Webpage: http://www.fedea.es/

FEDEA is a private non-profit research centre which was set up in 1985 to produce objective and independent economic analysis. It is aimed at fostering effective economic and social proposals through an understanding of their implications for individuals, families and businesses in Spain. FEDEA's research agenda has been shaped to reflect the problems faced by Spanish society down the years. Issues relating to the labour market, pensions and economic development have accounted for a substantial part of the work undertaken by the centre. Some of the best publications on pensions are elaborated by experts of this institution. Other topics, concerning innovation, the environment and immigration, also receive major attention. FEDEA's regular publications include a Working Papers Series, FEDEA Briefs and Bulletins, Economic Reports and Labour Observatory Bulletins.

Fundación de las Cajas de Ahorros (FUNCAS) - Savings Banks Foundation

Contact person: Victorio Valle (General Director)
Address: c/ Caballero de Gracia, 28 (28013) – Madrid
Phone: 0034 (0) 91 596 57 18
Email: www.funcas.ceca.es/contacto/Contacto.asp
Webpage: http://www.funcas.ceca.es/

FUNCAS is a private non-profit institution created and funded by the Spanish Confederation of Savings Banks (CECA). It is aimed at developing research on the socio-economic situation of Spain with a view to producing useful analysis and proposals for public political design and decision-making both at national and regional level. FUNCAS regular publications include several highly relevant scientific journals (Papeles de Economía Española / Perspectivas del Sistema Financiero / Economía de las Comunidades Autónomas / Cuadernos de Información Económica / Panorama Social), a Working Paper series and reports on macroeconomic and financial analysis. It also publishes individual books and collective volumes.

Fundación Juan March. Centro de Estudios Avanzados en Ciencias Sociales (CEACS) - Foundation Juan March – Centre for Advanced Studies in Social Sciences

Contact person: Magdalena Nebreda (Administration) / Ignacio Sánchez Cuenca (Research Director)
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Webpage: http://www.march.es/ceacs

The Fundación Juan March – CEACS is a research and advanced training centre on Sociology and Political Science. It produces scientific reports and working papers on compared institutional analysis, political and economical regimes, inequalities, social mobility and

labour market dynamics. The Foundation publishes a highly influential Working Papers Series and completes its research activities with seminars and conferences.

Fundación para el análisis y los estudios sociales (FAES) - Foundation for Social Studies and Analysis

Contact person:	Jose María Aznar López (President) / Fernando Navarrete (Director of Economics and Public Policy)
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Webpage:	http://www.fundacionfaes.es/

FAES is a private non-profit institution that works in the sphere of ideas and political proposals. The FAES has been linked to the Partido Popular since its creation in 1989 and constitutes a think tank committed to nurturing the political ideas and activities of this political party. FAES develops its activities through discussion groups, seminars, lectures and summer conferences at the FAES Campus. It also issues electronic publications, the magazine 'Cuadernos de Pensamiento Político', reports (FAES Papers Series) and books.

Fundación Primero de Mayo (Comisiones Obreras, CCOO) - First of May Foundation (Comisiones Obreras, CCOO)

Contact person:	Jorge Aragón Medina (Director)
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Webpage:	http://www.1mayo.ccoo.es/

The Fundación Primero de Mayo is the research institution of the trade union Comisiones Obreras. It is aimed at promoting analysis on social and economic issues with a special focus on employment, industrial relations and labour market dynamics. It is highly active in spreading knowledge through several regular publications including the Journal of the Foundation, reports and studies and other monographs and books.

Fundación Salud Innovación Sociedad – Foundation Health Innovation and Society

Address:	Gran Via Corts Catalanes, 764 (08013) – Barcelona
Phone:	0034 (0) 93 306 46 12
Email:	fundacionsis.phesba@novartis.com
Webpage:	http://www.fundsis.org/

FSIS is an institution financed by Novartis that shares its own projects and applied research in social sciences and epidemiology and provides opinions at the request of public and private bodies in the field of epidemiology, health economics and systems analysis.

Fundación Sistema - Sistema Foundation

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Email:	info@fundacionsistema.com
Webpage:	http://www.fundacionsistema.com/

The Fundación Sistema is a non-profit research institution that aims at fostering debate and exchange of ideas on social and political issues, including immigration and labour market dynamics, democratic participation and civil society, among others. The think tank Fundación

Sistema is independent in nature, although it has been ideologically linked to the Socialist Party (PSOE). The Fundación Sistema publishes regular informative bulletins and books.

Gaceta Sanitaria

The magazine Gaceta Sanitaria Doyma Editions is the official organ of the Spanish Society of Public Health and Health Administration. (SESPAS). It addresses public health professionals, Epidemiology, Preventive Medicine and Community and the Administration and Management of Health Services.

Contact person: Carme Borrell (editor)
Address: C/ Travessera de Gracia, 17-21 08021 Barcelona.
Phone: 0034 (0) 93 200 07
Email: gs@elsevier.com
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Instituto de Estudios Fiscales (IEF) - Institute of Fiscal Studies

Contact person: José María Labeaga Azcona (General Director)
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Phone: 0034 (0) 91 339 89 14
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Webpage: http://www.ief.es

The Instituto de Estudios Fiscales (IEF) is the Spanish public finance research and training centre. It is aimed at establishing and promoting forums for research on public finance and civil society. It is also responsible for developing training, specifically designed to address the analysis of the policies and strategic objectives of the Ministry of Economy and Finance. The IEF publishes several scientific journals ('Crónica Tributaria', 'Hacienda Pública Española. Revista de Economía Pública', 'Presupuesto y Gasto Público', 'Cuadernos de Formación', 'Foro Fiscal Iberoamericano'). It also issues a Working Papers series and a Working Document series, as well as books and individual volumes.

Instituto de Mayores y Servicios Sociales (IMSERSO) - National Institute for the Elderly and Social Services

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Address: Avda. de la Ilustración, s/n con vuelta a c/Ginzo de Limia, n.º 58. 28029 Madrid
Phone: 0034 (0) 913 638 592/ 593/ 594
Email: dg@imserso.mepsyd.es
Webpage: http://www.seg-social.es/imserso/

The Institute, created in 1978, is currently part of the new Ministry of Health and Social Policy. It manages complementary services of social security (i.e holiday programmes, thermal services, non-contributory pensions, etc) in the area of elderly people and dependants.

International Journal of Health Service

One of the major English-language health policy journals, the IJHS ranks in the top five for frequency of citation of its articles in the scientific literature.

Contact Person:Vincente Navarro (editor)
Phone: 6316911270
Email: Info@baywood.com
Webpage: http://www.baywood.com/Journals/PreviewJournals.asp?Id=0020-7314

Ministerio de Hacienda y Administraciones Públicas– Ministry of Finance and Public Administration

Address:	C/ Alcalá, 9 - Planta Baja. 28071-Madrid
Email:	informacion.administrativa@meh.es
Webpage:	http://www.minhap.gob.es/

It includes the Consejo de Política Fiscal y Financiera, CPFF- Council of Fiscal and Financial Policy.

Ministerio de Sanidad, Servicios Sociales e Igualdad- Ministry of Health Social Services and Equality

Minister:	Ana Mato Adrover
Address:	Paseo del Prado, 18-20, planta baja, esquina con Lope de Vega. 28014 Madrid
Email:	oiac@msssi.es
Webpage:	http://www.msps.es

It includes the Consejo Interterritorial del Sistema Nacional de Salud, CISNS- Interterritorial Council of the National Health System. Note: the Ministry is right now under re-organisation, so it is difficult to provide other contact details at this very moment. Among its many publications, the Annual Report of the Spanish National Health Care System should be highlighted (published since 2004), and also Main Figures of the Spanish National Health Care System. Journals published by the Ministry include: Revista Española de Salud Pública, Información Terapéutica del Sistema Nacional de Salud, Estudios sobre el Consumo, Boletín Epidemiológico Semanal, Medicina y Seguridad en el Trabajo.

Ministerio de Empleo y Seguridad Social - Ministry of Labour and Social Security

Minister:	Fátima Bañez Garcia
Address:	C/ Agustín de Bethencourt, 4, 28071 Madrid
Phone:	0034 (0) 91 363 23 30
Email:	informacionmtin@meyss.es
Webpage:	http://www.meyss.es

The Ministry of Labour and Immigration is concerned with the tasks in the fields of social security, immigration and emigration and employment.

Observatorio Nacional de la Dependencia – National Observatory on Dependency

Contact person:	Dr Jorge Garcés Ferrer (direction and management)
Address:	POLIBIENESTAR. Facultad de Ciencias Sociales. Universitat de València-Estudi General. Edificio Departamental Occidental. Campus dels Tarongers. Avinguda dels Tarongers s/n 46071 Valencia
Phone:	0034 (0) 96 382 81 84 / 82.02
Webpage:	http://www.uv.es/SocialWelfare, http://www.ondep.es/portal/portada/portada.aspx

This observatory has been created and is managed by the "Polibienestar" Research Unit, which is a leading group in Spain and the Valencian Region specialised in research, development and innovation, and management of social policies.

Obra Social "La Caixa"- Social Foundation "La Caixa"

La Caixa, is a savings bank that has an institution of social nature, so called Obra Social, a non-profit foundation. Its objectives are to contribute to the development of the territory, avoid

financial exclusion, encourage savings and investment, and conduct social work the benefit of citizens.

Contact person: Sr. Isidre Fainé Casas
Address: Avinguda Diagonal 615, 08024, Barcelona
Phone: 934 046 596
Webpage: http://obrasocial.lacaixa.es/home/obrasocial2_es.html

La Organización de Consumidores y Usuarios- The Organization of Consumers and Users
The Organisation of Consumers and Users (OCU) is a private independent non-profit organisation that began in 1975 with the aim of promoting and defending the interests of consumers, guiding them in their choices as a consumer, working to help them solve their problems consumption and to assert their fundamental rights as consumers.

Address: Calle Albarracín, número 21, 28037, Madrid
Phone: 0034 (0) 913 000 045
Webpage: http://www.ocu.org/

Organización Médica Colegial – Medical Associated Organization
The General Council of Official Colleges of Physicians (CGCOM) is the umbrella body, coordinates and represents the 52 official colleges of physicians nationwide and internationally, and has the function ofexclusive representation, management and protection of the medical profession .

Contact person: Juan José Rodríguez Sendín (president)
Address: Plaza de las Cortes, 11 - 28014 (Madrid)
Phone: 0034 (0) 91 431 77 80
Webpage: https://www.cgcom.es/
E-mail: webmaster@cgcom.es

Revista de Gestión Clinica y Sanitaria- Journal of Clinical and Health Management
Revista de Gestión Clínica y Sanitaria is a quarterly review of secondary literature published jointly by the CRES (Centre for Research in Health Economics, Universitat Pompeu Fabra of Barcelona), Gaspar Casal Foundation (Madrid) and the IISS (Institute Foundation Health Services Research, Valencia).

Contact person: Dr Ricard Meneu
Address: San Vicente 112, VALENCIA
Phone: 0034 (0) 609153318
Webpage: http://www.iiss.es/gcs/
E-mail: iiss@iiss.es o iiss_mr@arrakis.es

Servicio de Estudios del Ministerio de Trabajo e Inmigración – Research Department of the Minister of Labour and Immigration

Contact person: Julio Pérez Sanz (Minister's Cabinet Director)
Address: Agustín de Bethencourt, 4 (28071) – Madrid
Phone: 0034 (0) 91 363 01 32
Email: sdirgabmin@mtin.es
Webpage: http://www.mtin.es/

The Servicio de Estudios del Ministerio de Trabajo e Inmigración is a public body for research on social security, immigration and emigration dynamics and employment and labour market issues. It issues regular reports, statistics and guides on labour and social affairs. It also publishes books and scientific journals, including the Revista del Ministerio de Trabajo e Inmigración (Journal of the Minister of Labour and Immigration).

Sociedad Española de Geriatría y Gerontología (SEEG) – Spanish Association of Geriatrics and Gerontology

Contact person:	Dr. Pedro Gil Gregorio (president)
Address:	Príncipe de Vergara, 57-59. 28006 Madrid
Phone:	0034 (0) 91 411 17 07

SEEG is a Spanish national association of specialists in geriatrics and gerontology.

UNESPA (Asociación Empresarial del Seguro) – UNESPA (Insurance employers association).

Contact person:	Pilar González de Frutos (President).
Address:	c/ Nuñez de Balboa, 101 (28006) – Madrid.
Phone:	0034 (0) 91 745 15 30
Email:	gabinete.prensa@unespa.es
Webpage:	http://www.unespa.es/

UNESPA is the main employers association of the insurance sector in Spain. It represents more than 250 insurance firms, which constitutes more than 96% of the Spanish insurance market. It was created in 1977 to represent the professional, economic and social interests of its affiliates towards other private organisations and public institutions, both at national and international level. UNESPA also represents the collective interests of its members with regard to labour issues and particularly in the processes of social dialogue and concertation with workers' representatives and public powers at the industry level.

Unión democrática de pensionista y jubilados de España - Democratic Union of Pensioners and Retired Persons of Spain

Address:	c/ Alcalá, 178 (28028) – Madrid
Phone:	0034 (0) 91 542 02 67
Email:	informacion@mayoresudp.net
Webpage:	http://www.mayoresudp.net/

The Unión Democrática de Pensionistas y Jubilados de España (UDP) is a private umbrella organisation representing the interests of pensioners and retired workers. It brings together a large number of heterogeneous organisations of pensioners at regional and local level.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en